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MEN IN NURSING:
MASCULINE GENDER ROLE STRESS AND JOB SATISFACTION

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Anita Bailey

May 2014

MEN IN NURSING:
MASCULINE GENDER ROLE STRESS AND JOB SATISFACTION

By
Anita Bailey

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ABSTRACT

MEN IN NURSING: MASCULINE GENDER ROLE STRESS AND JOB SATISFACTION

By

Anita Bailey

May 2014

Dissertation supervised by Professor Richard Zoucha.

Men represent a minority in nursing who have until recently experienced limited scholarly interest. Existing studies indicate that men experience bias, discrimination based on sex, and disproportionate levels of discipline within the profession. In the face of a continuing nursing shortage, recruitment and retention of men, as well as the rates at which men leave the profession and factors associated with that turnover, are of concern. Masculine Gender Role Stress (MGRS) may play a part in men's responses to nursing culture and settings, and may influence job satisfaction in a manner that affects behavior and tenure. This descriptive correlational study examined relationships between MGRS and job satisfaction, as well as demographic variables of age, years in nursing,

employment setting, education level, ethnicity, and sexual preference. Participants consisted of 88 men nurses residing and working in Missouri, contacted by mail, and provided with informed consent. Questionnaires for the study were accessible online by computer. Completed data were analyzed by non-parametric tests including *Chi* square, Spearman's *rho* and Kendall's *tau b*. Results indicated that rates of MGRS were low among respondents, with less than 7% of this sample scoring high in MGRS. There was a non-significant inverse relationship between MGRS and job satisfaction, suggesting the possibility that the greater MGRS experienced, the less satisfied the individual was with his employment. MGRS was not significantly related to age, degree, type of nursing discipline, or sexual preference. For men nurses who prefer male sexual partners, MGRS sub issues of intellectual adequacy and ability to perform appeared significant on 2 of 5 factors. Several respondents commented on the “personal” or “inappropriate” nature of the questionnaire items, one called the questions “intrusive, obnoxious, poorly written, and fails to cater to advanced practice degrees”; however, the majority of the 22 comments suggested additional study directions or asked for survey results when available. There was no correlation between comments and MGRS or job satisfaction levels. Incidental findings were that married respondents were more satisfied with their employment and salary than single respondents.

DEDICATION

Richard D. Bailey

My Sunshine

ACKNOWLEDGEMENT

Richard Zoucha, PhD

D. Wayne Mitchell, PhD

Charles Larew, PhD

My long suffering and patient committee.

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Men in Nursing: Masculine Gender Role Stress and Job Satisfaction

Chapter One

Introduction

Men Understudied

Men employed as nurses comprise a group that has garnered little detailed research over the past decades. During the ten centuries in which nursing as a distinct role has existed, men contributed the greater part of nursing duties for all but the last 150 years (Mackintosh, 1997). When Florence Nightingale began the development of modern nursing, the tasks of the nurse fell more and more consistently to women (Schultz, 1992). By the end of the First World War, less than 100 men nurses were registered in England, compared to over 90,000 women nurses (Mackintosh, 1997). Since that time, men have gained a limited but increasing foothold in the profession, with the 2008 census (U.S. Department of Health and Human Services, 2010) showing 9.6% of nurses were men, in comparison to the year 2000 census (Spratley, 2002) which indicated that 5.8% of nurses in the United States were men. Today, men represent a minority group holding a controversial and challenged position within the profession (Evans, 1997).

Indications of Disparities Among Men Nurses and Women Nurses

As a minority population within nursing, men might be expected to experience issues that have historically troubled other minorities, such as exclusion from certain professional roles (Gaskin, 1995), being perceived as somehow wrong or inappropriate in their workplace (J. A. Evans, 2002), facing sexually demeaning harassment (Ware, 2002), or experiencing active discrimination against them within institutions because of their sex (Hawke, 1998). There are indications that these effects do occur preferentially to men

nurses more than women nurses, but few active research studies have examined the indications.

Differential treatment. In nursing schools the female pronoun has been used almost exclusively when referring to nurses (Chung, 2000) which separates the male nursing student into a category of isolation and marginalization early in his career. In 1995, the California Civil Rights Board found it acceptable that, due to his sex, a male nurse could be prevented from attending women in labor and delivery. His skills were competent and he had a clean nursing record. Male physicians were not excluded from the same obstetric setting. The hospital's female nursing staff had protested the male nurse's presence (Gaskin, 1995). Among legal cases that demonstrate a gender barrier in nursing culture, Hawke (Hawke, 1998) a male nurse was told "he couldn't work for the female patients because he was male" (p. 58). It was the nursing cultural boundary which provoked the response, rather than the needs of the patient.

Two studies reported that there was little variance in patient preference for male or female nurses (Chur-Hansen, 2002) even among gynecological patients (Lodge, 1997). Although both studies are small ($n = 176$ and $n = 91$ respectively), they suggest that male nurses may face both the standard regulatory inhibitions shared by all within the profession, as well as unwritten nursing cultural strictures on male participation.

Bullying and harassment. Men nurses experience the social stress of being bullied at higher rates than do female nurses. One study (Ericksen, 2004) utilized a random sample of assistant nurses who belonged to the Norwegian Union of Health and Social Workers. Of 12,000 nurses contacted, 6485 respondents (54.1%) were currently working in the field and completed the questionnaire. Of those, 3.8% ($n = 247$) were

men. Men (10.2%, $n = 25$) and women (4.3%, $n = 265$) reported being bullied at their place of employment within the last six months ($\chi^2 = 19.12$, $df = 1$, $p < .0001$). Male gender and the experience of being bullied was significantly associated (odds ratio = 2.29; 95% confidence interval = 1.39 - 3.78; $p = .001$). This association remained even when adjustments were made for background factors. The indication from this is that male assistant nurses are more subject to bullying than their female colleagues, again providing a stressor that may preferentially affect men nurses' satisfaction with their role or employment.

In a separate study, the rate of sexual harassment of male and female nursing students was found to vary, with males experiencing a higher rate of severe sexual harassment than females. Bronner, Peretz, and Ehrenfeld (Bronner, 2003) administered a questionnaire about experiences within nursing to male and female nurses and student nurses in Israel ($n = 487$). Women nurses reported more instances of mild to moderate forms of harassment, such as sexually-laced comments and gestures, than male nurses. However, 35% of male nurses versus 26% of female nurses were subject to severe harassment, such as unwanted physical contact with breasts or genitalia, or invitations to engage in sexual intercourse. Furthermore, male nurses responded significantly less assertively to severe harassment than did female nurses, frequently failing to report that the event took place. The psychological dynamic of reduced reporting of harassment may further play into men's level of satisfaction within the profession.

Assumptions about nurse sexuality. Men nurses may face unusual pressures with regard to gender and sexual behavior, which do not occur to women nurses. Social role perceptions of gender normalcy may disproportionately affect men nurses rather than

female nurses. Harding (Harding, 2007) examined the construction of ‘gayness’ among men nurses in a qualitative interview study involving 18 male participants in New Zealand. According to the author, there is a widespread public perception that men nurses are homosexual. Participants worked as nurses in critical care, education, administration, mental health, and in the armed forces. Although 11 of the participants were gay, all participants indicated that they thought most male nurses were of heterosexual orientation. Themes included participants making a point of emphasizing their heterosexuality by talking about their wives and children, and the increased sense of stress and social pressure experienced by men in the profession. Harding pointed out this problem succinctly in the abstract (p. 636), “There is a paradox between widespread calls for men to participate more in caring, and discourses which stereotype male nurses as gay” while at the same time “conflating homosexuality and sexual predation”. This study provides a helpful qualitative sense to men’s experience within the field, even as it identifies a stressor not encountered by female nurses.

Evans (J. A. Evans, 2002) described the male nurse experience as “complex and contradictory situations of acceptance, rejection and suspicion of men as nurturers and caregivers” (p. 441). Thus, male nurses experience a “heightened sense of vulnerability and the continual need to be cautious while touching and caring for patients” (p. 441) for fear that some contact may be misinterpreted as sexual advances. Nurses must maintain physical contact with patients in their care, but at the same time, male nurses’ touching female patients may be socioculturally interpreted as inappropriate sexual contact even though no such intention or suggestion is actually made (Barbaro, 1996; J. A. Evans, 2002).

Disciplinary actions. In general, men nurses are disciplined more harshly and at higher rates than female nurses. In *Lynn v. Deaconness Medical Center-West Campus*, a male nurse caught sleeping on the job was more severely disciplined than a similarly-discovered female nurse (Personnel Policy Service, 2003). Three separate studies conducted on nurses who encountered disciplinable offenses (Booth, 1998; Evangelista, 2008; Green, 1996) noted that formal discipline was disproportionately (18-19%) against men nurses, who represented less than 8% of the nursing populations in the studies. Disproportionate levels of disciplinary action suggest that men nurses are either unequally disciplined compared to women nurses, or that men have greater difficulty in adapting to nursing's demands than do women. Disproportionate discipline may be a harbinger of higher male nurse rates of separation from the profession, as well as decreased employment satisfaction. Statistically, men leave nursing at a higher rate than women do (NewsRx.com, 2002).

Gaps in Research Leave Contributing Factors Unexplored

Although there are indications that men nurses experience some degree of discrimination in the profession, there is little evidence or research to determine the source or factors contributing to this disparity. In several of the noted reports (Chur-Hansen, 2002; Gaskin, 1995; Hawke, 1998; Lodge, 1997), the suggestion was that nursing cultural boundaries acted as a significant factor in the repression of the men nurses' employment aspirations. The disproportionate discipline of men nurses hints, at the least, of a misfit between some men and the nursing profession (Booth, 1998; Evangelista, 2008; Green, 1996). However, there is little clarity on whether the misfit

arises from the culture of nursing or the men nurses themselves, or some interaction of both elements. The severity of the harassment (Bronner, 2003) men nurses endure, often without complaint, suggests that men's attitudes or internalized behavior schemas are at variance with the ones held by female nurses.

Although there may be other unknown factors at play, the elements noted here may be reduced to two broad primary factors, the interaction of men's role expectations and the cultural norms of nursing. These factors may represent social forces that are, by their intrinsic natures, difficult to mesh into a cohesive whole within the employment setting. The interaction of roles and culture provide insight into this complex issue.

The Interaction of Culture and Roles

Culture

Defined. Culture can be defined from sociological and anthropological perspectives. According to biological anthropologist Ralph Holloway (Holloway, 1969), culture is the method by which humankind organizes experience, an imposition of symbolic form on the environment. Leininger (Leininger, 1997) stated that culture reflects "the lifeways of an individual or a group with reference to values, beliefs, norms, patterns, and practices" (p.38). The concept of culture has also been described as having specific characteristics, including a set of patterns that constitute information, knowledge, and behaviors. These characteristics are based on social learning and symbolic conceptions. Shared values and practices also factor into the broader definition, as well as the recognition that there is an insider's (emic) and outsider's (etic) viewpoint on cultural behaviors (Leininger, 1995). Cultural values are learned and shared behaviors,

yet their rules are often unwritten and largely invisible to participants.

Culture shapes behavior. Children raised within one culture absorb their cultural norms and expectations from the actions of family and friends, as well as television and other role models to which they are exposed (Franzoi, 2003). Western cultural behaviors vary from those of the Middle East, Asia, and Far Eastern cultures. In addition, culture varies on progressively more particulate levels, progressing from the broad view of Western Culture down through, for example, California culture versus New York culture, and into such finer and more discrete levels such as ‘organizational culture’ and ‘family culture’. Culture may be understood to operate as an umbrella, with each succeeding level casting a smaller shelter over the participants. Additionally, each level of culture may have inter level variances, such that one family’s internal culture around the Christmas holidays might be highly religious whereas their neighbor family’s culture may follow pagan solstice traditions instead. Even so, both continue to act under the larger umbrella of their regional cultural norms with the still larger umbrella of Western culture presiding above all others.

Nursing is a culture. On the organizational level, nursing represents a distinct culture of its own. Nursing has been examined from the disciplinary perspectives of anthropology, sociology, ethnography, and history (Dougherty, 1985; Holland, 1993; Mackintosh, 1997; Suominen, 1997). According to Holland (Holland, 1993), nursing fits the minimal requirements for a cultural system in the sociological sense, including having a system of communication, a system of economics, methods for socializing new members, systems of authority and power distribution, and rituals which continue or improve social cohesion and give recognition to important personal events.

In addition, Holland reported that, historically, nursing's cultural system was promoted by caring for society's ill persons (Holland, 1993). Nursing established itself by developing a new knowledge based on the skills used in caring for the sick, and later formed subcultures with distinct dress, behaviors, and codes (such as school nurses, home health nurses, advanced practice nurses, and so forth). This cultural system was established primarily by the women who formed nursing into a profession.

Specific features of nursing provide behavioral expectations and the defining boundaries of nursing culture (Barbaro, 1996; Locsin, 2002; Tonuma, 2000). These include a focus on task orientation, ritualization of care, clear hierarchical structures, depersonalization of the patient (the pancreas in room 6), orientation to short term daily task goals rather than patient-oriented goals, emphasis on predicting outcomes as a way of valuing practice, cultural organization which meets the needs of staff and administration rather than the needs of patients, and the routine encouragement of nurses to forego personal safety. These cultural elements differ from both physician culture and from the generalized organizational culture of hospital operation although some characteristics, such as clear hierarchical structures, are shared. In this way, nursing has developed distinct social boundaries and ways of being that both support and direct the behavior of professionals within the discipline.

History of nursing reflects wider cultural shift to feminism. During the 19th century, nursing remained low status work, separated by sex and strongly influenced by Victorian cultural attitudes toward gender-appropriate behaviors. Nursing began acquiring social acceptability through the efforts of women religious, such as the Sisters of Charity, and reformers like Florence Nightingale during the mid-19th century

(Mackintosh, 1997). The American Civil War accentuated nursing's prominence as a separate discipline from medicine, although there was initial male physician resistance to the presence of female nurses in military hospital units. Nurses were not differentiated from laundresses and cooks, although social class and race played as much a part in the situation as gender (Schultz, 1992).

The strongly feminized aspects of nursing developed during the 19th century period, and as a consequence nursing became a female-dominated culture. For example, by 1931, England's national census only identified 100 men who listed their occupation as nursing, whereas during the period from 1921 to 1938 there were 97,028 new female nurses registered (Mackintosh, 1997). The feminization of nursing in part arose due to Victorian attitudes toward gender roles, in part from nursing's development out of underclass roots, in part due to the strength of women religious and Nightingales who led its modern resurgence, and to the professionalization of nursing that grew out of the Civil War (Schultz, 1992). Nursing culture's characteristics therefore derive from several factors: the dominance of females (Spratley, 2002); the historical development from under classes; and the current position of nursing in comparison to medicine as a lower status profession (Lips, 2001). The high degree of feminization of nursing culture may be a factor that contributes to the challenges men face within the profession, particularly if nursing cultural norms conflict with wider cultural role expectations for men.

Roles

Defined. According to role theory within sociology and social psychology, role represents a feature of social behavior. Role develops out of humankind's propensity to

form groups. Within each group people take on separate positions, such as leader, helper, or healer. These positions are called a role. The role's functions are built, in part, on the group's expectations for the actor in that role. Over time, expectations become formalized into norms, and social rewards and punishments may occur when one follows or transgresses role boundaries. Because of the rewards and punishments, people tend to conform to their proscribed roles. If people are compelled to carry out several roles that have differing expectations, they may experience distress related to role conflict (Macionis, 2006).

Gender roles, defined. Gender traits act as widely accepted and largely invisible cultural expectations placed on each sex (Lips, 2001). However, the conception of gender is considered to be different from the conception of biological sex (Kosslyn, 2004; Lips, 2001). Sex is defined as strictly biological and physiological characteristics. On the other hand, gender represents the nonbiological features of being either female or male, such as use of make-up and manner of dressing.

Gender roles also include the cultural expectations for femaleness or maleness behaviors, and the cultural parameters for male and female roles (Jackson, 1985). These parameters vary sociologically and anthropologically from culture to culture, with different societies placing greater or lesser emphasis on the performance and outward evidence of one's maleness or femaleness (Franzoi, 2003). In this study, gender role will refer to the social or cultural expectations for specific stereotypic sex-based behaviors.

Male gender role. In general, individuals of male sex will exemplify proportionally more masculine gender role behaviors than female role behaviors. Not all members of a sex may share gender specific characteristics. Most people represent these

traits on a continuum, rather than being exclusively male or female gendered.

Within gender roles, specific gender stereotypes represent core or prototypical traits associated with each role (Lips, 2001). The internalized capacity to stereotype another person by gender prototypes develops early in life. Two-year old toddlers have been able to sort photographs by gender without difficulty (Franzoi, 2003). Although the term stereotyping has garnered negative connotations, for this study it is considered a neutral feature of normal cognitive processes.

In Western societies, the male gender role stereotype or prototype is associated with instrumental (Franzoi, 2003) or agentic (Lips, 2001) personality traits – that is, the qualities perceived as forceful, severe, assertive, achieving, active, independent, unemotional, stable, strong, competitive, rational, dominant, and possessing sexual prowess. Female gender role prototypes, in contrast, are defined by “expressiveness” or “nurturance” qualities. These female gendered qualities include being affectionate, appreciative, caretaking, complaining, dependent, domestic, emotional, frivolous, gentle, nurturing, sensitive, softhearted, and submissive (Franzoi, 2003; Lips, 2001). Thus, culturally, each gender displays specific behavioral characteristics that are both complimentary and contrary to the other (Jackson, 1985).

Men differ from women physiologically. In addition to the differing gender role behaviors that are cultural norms, research has confirmed that biological sex-related differences do exist. Men differ significantly from women in multiple arenas, although the social effects of these differences remains controversial. Differences include primary motivators (Knight, 1989), role behaviors (Meany, 1985), communication of emotions (Wagner, 1993), spatial perception (McGee, 1979), the ability to systematize information

(Baron-Cohen, 2003), semantic fluency (McGuinness, 1990), social expectations (Pommerantz, 2002), physical perception of pain (Riley, 1998), risk-taking (Poppen, 1995), reproductive selection (Betzig, 1993), environmental sensitivity, intimacy and sports preferences (Rhodes, 2004), intellectual precocity (Benbow, 1986), aggression (Feshback, 1978), and patterns of brain development (Baron-Cohen, 2003).

The indications from this body of research are that there are some differences between men and women that are not solely the product of social role construction. These differences appear to stem from physiological biology rather than culture. As such, the differences appear to be hormonally hard-wired into both male and female brains prior to birth, and possibly as early as at conception when the embryo's sex is established in its DNA.

Nursing Cultural Expectations Discordant with Male Gender Role Expectations

If there is discordance between feminized nursing cultural expectations and male gender role expectations, some evidence should exist in literature that characterizes the issue. One of the most lucid examples of this discordance arises out of a concept fundamental to nursing, the conception of caring.

Caring. Caring is frequently used as a defining term of nursing itself (Mendyka, 2000; Oren, 1985; Valentine, 1989). Valentine's Integrated Caring Model (1989, 1990) describes caring as a complex set of core psychological features which are both cognitive and affective, and which are purposefully enacted during interactions with the sick. If there is a single term most often associated with nursing, it is caring.

Gender differences, however, influence how caring is demonstrated. In a Finnish

study, male nurses ($n = 39$) were less likely than female nurses ($n = 79$) to form trusting alliances with patients or to carry out comforting actions (Greenhalgh, 1998). In other words, men nurses were less likely to perform female-style caring behaviors. This is a distinct difference in male and female behavior styles related to caring.

Furthermore, Holyoake (Holyoake, 2001) found that men nurses considered “not caring” (p. 88) an appropriate male nurse behavior. That is, being above emotional involvement with the medical situation was considered the proper action for a man nurse. Maintaining behaviors that demonstrated their lack of emotionality was a critical feature of their maleness, and also seen as the appropriate way to handle patient care. For a male nurse, it may become difficult to reconcile male role attributes of emotional stoicism with nursing’s cultural demand for emotive caring actions.

In these few studies devoted to male and female nurse perceptions of caring, differences are apparent. Without a shared definition of caring that has specific parameters, majority opinions tend to persevere. In nursing, therefore, the female perceptions of caring became the nursing cultural standard by which nursing behaviors are judged. This marginalization of men who perform ordinary male role behaviors places men nurses at a professional disadvantage.

Cultural taboos and the male nurse. Cultural taboos affect behaviors within nursing culture, as well. In order to carry out taboo actions, such as asking for a stranger to disrobe, intimately observing a stranger of the opposite sex, or requiring a confession of personal details to a stranger, the nurse must be able to override cultural rules about forbidden social contacts. Strange (Strange, 2001) stated that much of nursing’s ordinary care and examination routines exist to safely breach the wider society’s cultural taboos.

In the hospital or outpatient setting, incidents of this type occur, for example, when bathing patients, when urinary catheterization is performed, and when asking patients about their medical histories. Strange suggests that taboos are overridden through the process of renaming. When asking for nudity, for example, the process is renamed into the caring transaction of physical examination. In that way, the behavior is ritualized with certain standards ascribed to it, and made acceptable to the cultural norms.

Broaching cultural taboos in nursing has been a particularly difficult area for men nurses. This difficulty has been illustrated (J. A. Evans, 2002) by the “sexualization of male touch” p. 441) that may occur in nursing situations. The wider cultural norms that prohibit men from touching women may be more difficult for men nurses to override, even within the caring transaction model, simply because the male role stereotype includes sexual aggression as a characteristic. The prohibition of a male nurse from labor and delivery rooms discussed by Gaskin (Gaskin, 1995) may have arisen from just such a conflict, completely unrecognized by the participants. This discordance places men nurses at another disadvantage, and may generate stress related to maleness as well as their roles within society and within nursing.

The Outcome of Culture and Role Misfit: Masculine Gender Role Stress

Men who hold strong concepts of their gender role may experience distress if they are required to behave in a way that is contradictory to their role. So, if nursing’s primary cultural expectation of caring conflicts with a man’s personal role expectations, a true role strain may occur.

Role strain takes place when incompatible role demands are incorporated into a

single status occupied by that person (Hirsch, 2002). This may occur if a male nurse is expected to perform feminized nurse role caring behaviors, while retaining his own male role non-emotive behaviors. This conflict has not been researched in nursing literature until recently. However, in social psychology, a concept does exist that clarifies this difficulty, masculine gender role stress.

MGRS defined. Masculine gender role stress (MGRS) is a psychogenic reaction specific to men, first discussed by Eisler and Blalock (R. M. Eisler, & Blalock, J.A., 1991). Cultural role expectations are internalized by both men and women and become the more formalized gender roles (Gray, 1999; Kosslyn, 2004; Lips, 2001). MGRS occurs under two circumstances: when the individual does not fulfill the internalized behaviors of his gender role; or when he feels pressured by situational elements to perform in a manner contrary to his internalized gender role (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988).

MGRS occurs as expectation and role collide. One feature of male role norms is that men are expected to avoid performing feminized behaviors. Simply being perceived as working in a largely female profession may generate MGRS in some men (D. R. McCreary, 1994) because it conflicts with male role norms. Female gender role stress, the complement to MGRS, has also been identified in women who believe they are unable to fulfill the female gender role, or when compelled to carry out masculine behaviors. Role stress increases proportionally with the tenacity by which the gender values are held (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988).

Situations that are threatening to a man's role expectations may precipitate unrecognized anxiety or stress (R. M. Eisler, & Blalock, J.A., 1991; D. R. McCreary, &

Sadava, S.W. , 1995). These feelings may be expressed in ways that are not obviously related to the initiating situation (Isenhardt, 1994), and include abuse of alcohol or drugs in response to a conflict on the job. Whereas masculine gender role standards require a man to be competent, in control, to demonstrate sexual prowess, and be accomplished in his work, MGRS may be generated by experiencing incompetence, lack of control, doubts or questions about his sexual capacity, or difficulties at work. Additionally, situations that call for prototypically female behaviors, such as nurturing, expressions of compassion, or expressions of emotions, may generate MGRS because these behaviors are also outside the maleness gender roles of society (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988).

MGRS is measured using a specific tool developed by Eisler, Skidmore and Ward (1988) called the MGRS Scale. The measurement of specific MGRS levels is based on recognition of male role characteristics which occur in five primary domains of traditional attitudes toward maleness (D. R. McCreary, Newcomb, M.D., & Sadava, S.W., 1999). These domains represent physical adequacy, emotional expression, subordination to women, intellectual adequacy, and ability to perform. These domains incorporate issues revolving around status, power, control, and sexual prowess.

The greater the man's concern about his status, power, control, or sexual prowess, as reflected through the five domains, the higher his MGRS scale score. An elevated score represents greater masculine role stress, whereas a lower score represents less internalized stress. Elevated levels of role stress have been associated with greater risk taking behaviors (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988), decreased self-care behaviors (O. Evans, & Steptoe, A., 2002), alcohol and drug abuse (Isenhardt, 1994; D. R. McCreary, Newcomb, M.D., & Sadava, S.W., 1999), inhibited social behaviors (Sauer,

1990), development of anxiety disorders (Shear, 2000), and detrimental health changes (Watkins, Eisler, Carpenter, & Schechtman, 1991). Factors that precipitate masculine gender role stress, then, may inadvertently lead to or exacerbate other problems in a man's life.

The Problem

The available research suggests that male gender role expectations may promote a misfit with nursing cultural expectations, leading to masculine gender role stress in some men. There is no existing nursing research that explores this indication. However, there may be another indicator that would provide evidence for a man's fit or misfit within the nursing profession. One possible indicator would be the concept of job satisfaction.

Job Satisfaction

Employment satisfaction, the sense of being content with one's job, has been shown to be correlated with length of employment, lower rates of disciplinable actions, and higher wages (Tovey, 1999). Research has shown that the nursing profession's primarily female demographic has similar demonstrated sentiments about employment in nursing (Adams, 2000).

There are several instruments used to examine job satisfaction. One that has been used repeatedly in testing nursing job satisfaction is the 31-item Mcloskey/Mueller Satisfaction Scale (MMSS), (Mueller, 1990). It explores elements of autonomy, communication, financial rewards, promotion, co-worker relationships, supervision, workloads, and work demands. Its focus is on eight work factors: extrinsic rewards (salary, vacation); satisfaction with work schedules; balance between family and work;

co-worker interactions; professional interactions; opportunities for professional advancement; recognition, and control and responsibility. In prior nursing studies using this tool, results were primarily based on the female nurse demographic with small numbers of male nurse participants. As such, it may tend to reflect more female preferences than male preferences in employment satisfaction.

Little prior research exists to demonstrate men nurses' rates of satisfaction or dissatisfaction within the profession. Men do leave nursing at a proportionally higher rate than women do (NewsRx.com, 2002), and are disciplined at disproportionately higher rates (Booth, 1998; Evangelista, 2008; Green, 1996). These results may indicate that men tend toward greater job dissatisfaction in nursing, or that because of misfit men do not stay in nursing as consistently as women do. Clearly, job satisfaction within the profession may be related to multiple elements inherent in employment itself, but may also reflect the congruence of the male nurse's conception of his gender role in relation to his professional nursing demands.

MGRS and Job Satisfaction

There are no studies which clarify whether men nurses who hold strict masculine gender role templates may experience greater or lesser job satisfaction in the profession. However, as Tovey and Adams (1999) reported, lower job satisfaction is associated with shorter terms of employment, and men do leave the profession at higher rates than do women (NewsRx.com, 2002). This suggests that men nurses tend to be less satisfied with their employment than are women nurses.

Masculine role stress, as MGRS, may be one causal link between men nurses' job

satisfaction and tenure in the field. If MGRS is indeed a factor, there would be an expectation that higher rates of MGRS would be associated with lower rates of job satisfaction. Additionally, the inverse might also be found, higher job satisfaction correlated with lower MGRS. No studies regarding this correlation were discovered.

Exploring the Problem

This research examined the relationship between MGRS job satisfaction. Results may help explore the possibility of a misfit between nursing culture and the men who hold strong role expectations. It is also possible that men who do not experience misfit within nursing culture are more likely to stay in the profession and achieve higher levels of education. If so, it may be possible to use educational level as an indicator of male nurse MGRS status, as well as job satisfaction.

Research Questions

1. What is the incidence of MGRS among men nurses? This question explored both the straight-forward incidence of MGRS, as well as the incidence of MGRS in relation to descriptives including employment setting, sexual preference, ethnicity, years in nursing, and marital status.

2. What is the correlation between MGRS and job satisfaction indicated by MMSS scores? This question was seeking indication of a relationship between MGRS and job satisfaction,

3. Is there a difference in level of MGRS and job satisfaction by highest level of education in nursing? Higher levels of education within a field suggests greater commitment to the discipline with related job satisfaction. MGRS may act as a factor that

compels or restrains advancement within the nursing profession for some men nurses. This question examined whether or not education level reflected the prevalence of MGRS and job satisfaction.

Significance

The presence of MGRS among men nurses may both result from and precipitate behaviors that are inimical to nursing actions inherent in nursing culture or even to the disproportionate levels of discipline experienced by men nurses. However, no prior studies have been completed which demonstrate the existence of MGRS among men nurses working within nursing culture, the relationship of MGRS with male nurse education within the profession, or whether or not MGRS is associated with continuing employment as a nurse. No studies specifically exploring male nurse job satisfaction were found.

During this era of severe staff shortages and understaffing, retention of men nurses merits greater attention. The presence of men in nursing plays a significant role in the care of male patients, as well as impacting the cost and quality of care received by all patients. The interaction of MGRS and job satisfaction may be an important part of developing and retaining men in nursing. As nursing actively solicits the participation of men in the profession, the ramification of the male response to role stress and its effect on job satisfaction will play an increasingly important role in studying male nurse patterns of employment, job satisfaction, and longevity in the profession.

Theoretical Basis: Role Theory

The concepts of social roles, role norms, and role-associated behaviors underlies much of this study. As such, the broad utilization of Role Theory as a theoretical basis provides both a structural outline of how role expectations develop, as well as clarifies how role conflicts can contribute to personal distress and social disorder. The interaction of male role expectations and the expectations inherent in nursing may contribute to significant distress for some men nurses.

Conceptualization of Roles

Role Theory is a concept developed in sociology and psychology. Mitchenher and DeLamater (Mitchenher, 1999) suggested that it is a foundational and compelling theory that connects social structure with personal behaviors. Much of role theory was developed greater than half a century ago, and was elucidated by Biddle (Biddle, 1966) in a form that has changed little since that time.

The theory suggests that our actions and behaviors are guided by expectations: those we personally hold, and those held by other people. These expectations correspond to the various roles a person acts out on a daily basis, such as the role of nurse. A nurse's role might include checking an ill person's temperature, charting observations, and providing medications. These role expectations vary from what might be expected of a truck driver or of a waitress, for example. Consequently, by naming a person's role as nurse, expectations are placed upon him or her that are unique to that role. Role expectations are encultured, that is, specific to the social setting and culture in which they occur.

Role expectations are so ubiquitous that they are predictive. It is possible to predict an individual's behaviors by knowing their role. An individual identified as a postman, for example, would not be expected to check an ill person's temperature, chart observations or provide medications. He or she would be expected to bring mail to one's place of business, or collect mail from a drop box located on a street corner. Role Theory suggests that much of people's daily activity consists of the performance of their specific roles. The role itself provides a structure for behaviors, goals, tasks, and actions that are appropriate in any given situation or setting.

Role Performance

According to Role Theory, a person may perform different roles at different times. In this way, the person who acts as a nurse during their workday may go home to perform the various roles of spouse, parent, housekeeper, gardener, and cook as well, transitioning between roles in a seamless and effortless fashion. Roles also may overlap, so that the work-a-day nurse uses his or her nursing skills while in their role as parent to a sick child, too. This concept may overlap the structuralist viewpoint, or may be seen as the individual's ability to take on separate roles depending on circumstances.

Roles and Personal Change

Role Theory holds that the means to change one's actions or behavior is to first change one's roles. This is primarily a cognitive change, which is then followed by a behavioral change. An example of this is the change from college student to floor nurse, wherein the individual mentally must adjust from the role of receiver of information, into

the role of provider of health care. The transition occurs after passing through multiple 'gates' and trials, and by absorbing and acting out role-appropriate behaviors. The transition in this case is marked by ceremonies and rituals, such as graduation from college, the nurse pinning, taking state or national tests, and receiving permission from higher authorities to act out the role of nurse. Many major role transitions, like marriage, are also marked by ritual or ceremonial events such as tests or celebrations.

Role and Beliefs

The acquisition of specific roles also influences the individual's beliefs and attitudes, so that these change to correspond with those associated with the role. At the same time, the individual influences the behaviors, expectations, and norms associated with their role in a reciprocating fashion. Consequently, roles are both stable and gradually changing, reflecting changes in a society and culture over time.

Derived Concepts

Role conflict. Conflict in one's roles occurs when contradictory or incompatible role behaviors are expected. For example, a person who perceives himself in the role of creative artist may experience role conflict when required to take on the role of businessman and negotiate sale contracts.

Role confusion. Confusion over one's role may occur when an individual experiences difficulty in determining the role that he or she should carry out. This may occur when a role is vaguely defined, or during transition between roles. An example of this is when a person who has carried out the role of patient meets his provider at a social

event, and finds himself in the new role of social equal. The change from role position of supplicant to social equal may result in confusion over the way to greet the provider, or even how to address him or her, as well as uncertainty over appropriate levels of interaction.

Role distance. Distance represents the separation between the individual and the expectations of his or her role, and the separation between role and the performance of that role. Distancing oneself from one's presumed role includes the expectation that there is an outside observer or audience for the distancing behavior. Examples of this would include the actions of young adults in public who avoid being seen with their parents. They are distancing from the role of child and seeking to take on the role of autonomous adult.

Role embracement. Embracement occurs when an individual 'becomes' their role, investing thought, activity and significant attention to the performance of the role. Complete role embracement may result in the submersion of the individual so completely into the role that the ordinary self becomes invisible; the person becomes the personification of the role. The late actor, Clayton Moore, who played the Lone Ranger on the children's television series in the 1950s appeared to fully embrace his role as the Lone Ranger, including wearing the Lone Ranger mask in public. Moore continued to dress and appear as the Lone Ranger for four decades after the series ended (Wikipedia, 2010).

Role strain. Strain may occur when a person experiences difficulty in fulfilling role expectations. For example, a woman who held the role expectation of keeping a home spotlessly clean may experience role strain if the residence became disordered by

the presence of children or pets.

Limitations of Role Theory

The theory is unable to predict deviance from social norms when the deviance is not related to a specific role. Consequently, bizarre behavior such as might be exhibited in psychosis cannot be ascribed to role, and role theory has no explanation suitable for such behavior. In addition, role theory is absent a historical function in that it does not view roles within the passage of time, or with a past to present to future orientation. That is, roles are seen as actions within the present, not as the outcome of past incidents or with consideration for potential future events. Role theory does not include speculation on the factors or elements that contribute to role change over time.

Application of Role Theory to This Study

Discussions in the preceding section of this chapter defined and described elements such as gender role, male role, and the concept of Masculine Gender Role Stress (MGRS). Each of these concepts arise from Role Theory, and are dependent upon the concepts of the theory to help elucidate their meanings and significance. Portions of Role Theory, in particular, have special applicability to consideration of men nurses' experience, including role strain, role confusion, and role distance. Role Theory may not be able to explain how nursing culture came to attribute specifically female characteristics to nurses. However, the theory does help to explicate the discordance between feminized nursing roles and socially encultured masculine and male roles.

Although it will not be explored in depth here, job satisfaction may also be related

to role expectations and role performance issues. Previous analysis of multiple studies (Schuler, 1975) had linked job satisfaction and role stress or role expectations across organizations. The correlation of job satisfaction with MGRS, therefore, may help elucidate a set of relationships which have not previously been explored.

Chapter Two

Review of Literature

A search of literature was conducted utilizing research databases available through Duquesne University and Missouri State University including EbscoHost, PsycINFO, CINAHL, and Sociology:Sage. Searches utilized major category terms such as “men nurse”, “male nurse”, “nurse”, “gender role”, “male gender role”, “nursing culture”, “nursing roles”, “nurse job satisfaction”, “male nurse employment”, “male nurse job satisfaction” and Boolean variants. The search was conducted until saturation of titles occurred, with the same articles and authors appearing in succeeding searches. EbscoHost’s list returned 848 possible articles, six of which were appropriate to the topic. Cinahl returned 94 articles, repeating those found in EbscoHost. Sociology and PsycINFO provided 78 possible articles, three of which dealt with men nurses; only one was less than 20 years old.

Seven articles were admitted to this review. Due to the small number of articles, inclusion criteria was specificity of relevance to men nurses. Methodology varied and included interview, survey, and laboratory testing, with sample sizes ranging from 18 to greater than 20,000 nurses in Israel, Scandinavia, New Zealand, the United Kingdom, and the United States.

A subsequent online search was conducted to explore the utility of the MGRS instrument. This search was conducted via access through Duquesne University system and PsycINFO database. Utilizing the terms masculine gender role stress and MGRS, 89 articles were returned and four were directly applicable to this study. Sample sizes ranged from 123 to 2,239. Methodologies included survey, completion of scales

evaluating various dimensions of personality, and clinical tests of blood pressure and heart rate.

Examination of the literature suggested three primary areas of integration between elements of this study: job satisfaction, men's experience in the nursing role, and MGRS. The interaction of these factors represents the predominant areas of interest for this study.

Job Satisfaction

Nurses' satisfaction with their employment has been explored for several decades. Multiple studies, often focusing on a specific population of nurses such as hospital based nurses (Busier, 2000), community nurses (Traynor, 1993), nurse practitioners (Wild, Parsons, & Dietz, 2006), female nurses (Sand, 2003), and psychiatric nurses (Berg, 1999), have been conducted. Other studies explored relationships between satisfaction and the existence of collaborative care (Abbott, 1994), the effect of a professional practice model within the organization (Pierce, 1996), and the effects of intrinsic motivation (Lawler, 1970).

Role Conflict

Tovey and Adams' (Tovey, 1999) study explored changing sources of nurse satisfaction. Utilizing a random sample of 130 English participants, they found that elements of role conflict, lack of job security, lack of resources, introduction of new technology, lowering standards of patient care, increasing paperwork, and rapid environmental change contributed to decreasing job satisfaction. No breakdown of results by nurse gender was included in this study.

Nurse-Environment Misfit

In an issue that may be applicable to men nurses working in feminized nursing

culture, Takese, Kershaw, and Burt (Takase, 2001) explored the effect of other's stereotypical views of nursing on nurses' job satisfaction. Their descriptive correlational study investigated nurses' reactions to the discrepancy between the images of nursing held by the public and by nurses. They compared these reactions with nurses' self-concept, job satisfaction, and performance. Using a sample of 80 Australian registered nurses, participants completed the Porter Nursing Image Scale, Index of Work Satisfaction (IWS) and Six-Dimension Scale of Nursing Performance tool. Analysis was by descriptive statistics and Pearson correlation. Results indicated that discrepancies in perception of nursing compared to the realities of nursing could contribute to nurse-environment misfit. With greater misfit, satisfaction and job performance decreased.

The results suggested that there was a discrepancy in the images of the nursing profession between nurses and the public, which contributed to the nurse-environment misfit. While the results are not directly applicable to men nurses, the ability of nurses to tolerate a misfit between other's perceptions and one's reality may illustrate significant issues for men. As Holyoake explained (Holyoake, 2002), men nurses are curios whose identity is created for them by perceptions of others in the profession. Consequently, an individual male nurse's fit or misfit within the profession may be mitigated by factors other than skill. Such factors may include gender norms, which are social constructs rather than the male nurse's personal conceptions.

Interpersonal Relationships

The effect of positive interpersonal relationships may play a critical part in nurses' satisfaction with their employment (Adams, 2000), but studies are unspecific in

identifying gender-related preferences. Adams and Bond focused on 834 nurses. Their results indicated that interpersonal relationships were significantly important to job satisfaction. Higher levels of employment also were associated with satisfaction. Although this study analyzed outcomes based on job levels, no analysis by gender was indicated. No studies specifically exploring men nurses' job satisfaction was found.

Study Implications

These studies suggest that nurse job satisfaction is influenced by factors over which nurses have little control, such as organizational changes, technology, and interpersonal elements. The fit or misfit between social perceptions of the nursing role, and the realities of that role, may contribute to employment satisfaction and longevity. Cultural perceptions and social perceptions often run hand-in-hand.

Although these studies imply that nurses encounter particular role-related variances that may initiate feelings of satisfaction or dissatisfaction, there is no indication if these outcomes are primarily female-specific. For example, organizational changes and technology upgrades may be easier for male nurses to incorporate into their routines than for female nurses. Alternatively, men in nursing may be less likely to value social perceptions of their nursing roles than do women nurses, precisely because they have chosen roles at variance with social expectations.

Men's Experiences in the Nursing Role

Popular reports and scholarly studies indicate that a portion of men's experiences within the profession promote dissatisfaction, or at least an awareness of stressors and

lacks within the work environment. There are no studies that indicate if this may be the product of a type of misfit between the man's expectations of the profession and the reality of nursing work.

Differential Treatment

The appearance of differential treatment based on gender may represent complex factors that are not readily apparent within nursing culture. Disparities in disciplinary actions (Booth, 1998; Evangelista, 2008; Green, 1996), the higher rates of men leaving the profession (NewsRx.com, 2002), the higher rates of sexual harassment and bullying that men nurses experience (Ericksen, 2004), as well as the widespread social assumptions about men nurses' sexual preferences (Harding, 2007), place different expectations and pressures on men nurses than on female nurses. In addition, other factors may come into play creating a misfit of men in the nursing culture, including being a visible minority, the avoidance of appearing feminine, the widely believed assumption that nursing administration favors men over women, and existing evidence that men experience higher levels of physiological stress in the profession, all may contribute to the wider issue, as well as providing fertile ground for further research.

Visible minority. Being a member of a minority tends to promote increased visibility, as well as increased scrutiny. Simpson (Simpson, 2004) interviewed 40 male workers in four occupations generally thought of as women's jobs, steward on airliners, librarians, primary school teachers, and nurses. The author extracted themes including different modes of entering the profession including actively seeking work in the discipline, finding oneself there, and deciding to settle into a female dominated field after

working in a male dominated one previously. Other themes emerged that men working in women's career fields also tended to assume leadership positions in part due to their minority status and visibility, were accorded differential treatment, and tended to have a greater careerist attitude toward employment than female colleagues. These results strongly apply to effects seen in nursing, as well.

Avoiding femininity. Additional themes of re-labeling, status enhancement and distancing from the feminine also emerged in Simpson's 2004 study, as participants sought to re establish masculine identity within their workplace. This study suggests that men working in female-dominated fields, such as nursing, deal with different issues than do women in their disciplines, including minority status, visibility, a need to differentiate from colleagues by sex, and focus on gender identity. Women in nursing do not include these factors among stresses they experience.

Proportion of men in administration. There is a widely held belief among women nurses that men are unfairly promoted to administrative levels due to patriarchal structures in nursing (Evans, 1997). However, male representation in the administration of nursing has been found to be proportional to their presence in the profession. Snyder and Green (Snyder, 2008) utilized data from the National Sample Survey of Registered Nurses in the US from 1977 to 2000 to determine the representation of men in nursing administration. Sample sizes from each survey year numbered greater than 20,000 participants. The outcome demonstrated that men were represented proportionately in nursing administration, contradicting the conventional belief of male over representation.

Snyder and Green (2008), however, did find evidence of horizontal segregation. Interviews were conducted with a small samples of participants separate from the existing

surveys (N=11), which found that men and women nurses disproportionately clustered in gendered specialties – more female nurses in labor and delivery, more male nurses in critical care and emergency, for example. The authors noted that male nurses tended to cluster in more ‘masculine’ fields. Their conclusion was that male presence in nursing fields was the product of horizontal sorting and the effect of limited availability of top positions in the discipline. There is no indication of how such sorting may influence employment satisfaction among men nurses, particularly those qualified individuals who are unable to rise to higher levels in nursing hierarchy due to a lack of openings.

Signs of Physical Stress Among Men Nurses

Deane, Chummun, and Prashad (Deane, 2002) tested urinary levels of cortisol, adrenaline, and noradrenalin among male and female nurses. Both groups tested higher than the non-nurse average, but male nurses tested significantly higher than comparably aged pre- and post menopausal female nurses. For cortisol levels in 20 to 40 year old nurses, males tested 83.3% higher than females, and for 41 to 65 year old, males were 26.5 % higher. Adrenaline was 44.6% and 9.5% higher, and noradrenalin was increased by 26.4% and 6.2% for the age groups respectively ($p < 0.001$ for all examples). Higher levels of stress hormones may suggest that men nurses are subject to unique stresses that females do not experience, that male nurses react more strongly to stresses, or that females are better able to accommodate the demands of nursing and nursing culture.

MGRS Indicators

The previous study suggests that male nurses experience more physiological stress than female nurses. The source of that stress was not explored. In a similar

fashion, if MGRS is an actual stress men experience, there should be physiological and psychological signs of that stress. In research, MGRS has been found to be associated with significant stress reactions.

MGRS and the Male Role

In an interesting and cleverly constructed study, Cosenzo, Franchina, Eisler, and Krebs (Cosenzo, 2004) explored the relationship between cardiovascular reactivity, serial subtraction (cognitive) performance, and high or low MGRS scores. Previous studies had shown that the demand characteristics of a task, and male participant's appraisal of the task as being related to their masculine gender identity, led to increased cardiovascular reactivity (CVR). CVR was identified by systolic blood pressure (SBP), diastolic blood pressure (DBP) and heart rate (HR). This study sought to find if there was any relationship between MGRS, CRV, and cognitive performance as measured by serial subtraction tasks.

Male participants from undergraduate psychology courses ($N = 123$) were tested utilizing the MGRS, and subsequently divided into high scorers at 95 points or above ($M = 120.22$, $SD = 19.51$, $n = 36$) and low scorers at 76 or lower ($M = 59.56$, $SD = 12.93$, $n = 36$). The high and low MGRS participants were then monitored by an automatic blood pressure testing device and given test instructions that were either gender relevant (GR) or gender irrelevant (GI).

GR instructions included such statements as “*We expect men to perform very well on this task because of men's high aptitude in math and logical analysis...[this] is what*

make men leaders in science, sports, and business...they typically don't get flustered on these tasks, certainly relative to women". The GI instructions included non challenging variants, *"We expect that your performance on these cognitive tasks may affect your heart rate and blood pressure."* As a result, the high MGRS group demonstrated greater changes in SBP in response to the GR instructions than did the low MGRS score group (MGRS x Instruction condition x SBP change, $F(1,68) = 3.97, p < .05$). SBP increased significantly from baseline to 1 minute with GR instructions in the high MGRS group but not in the GI instruction condition ($F(1,34) = 8.02, p < .01$). Similar results were noted for HR in the high MGRS group in the GR condition over three trials when submitted to repeated measures ANOVA (trials x MGRS x instruction condition $F(2,136) = 3.14, p < .04$). During the cognitive task (serial subtraction), the high MGRS group performed more errors during the GR condition than the GI condition and more errors than the low MGRS group in either condition. Effect size analysis for the significant results in the GR condition was a Cohen's d of 0.87.

This one interesting study indicated that the simple statement used to prime the participants, that men should score better because they are men, was sufficient to generate significant distress among participants. Men with higher MGRS scores, that is, the men who tenaciously hold views of their masculinity, experienced greater physiological signs of stress and difficulty with thought when they perceive a threat to their masculine self-appraisal. If a single sentence of instruction is sufficient to generate this kind of distress, it suggests that a daily routine of repeated role stress could create chronic stress effects in susceptible men.

MGRS and Psychological Distress

The threat to a man's view of himself may be elevated in professions in which men perform in non-masculine ways, such as in nursing. Men with more strict gender conceptions may consequently undergo greater personal conflict, stress, and decreased job satisfaction. If the male nurse finds it difficult to confirm his masculine role expectations, stresses may lead to maladaptive behaviors.

Arindell, Kolk, Martin, Kwee, and Booms (Arrindell, Kolk, Martin, Kwee, & Booms, 2003) explored whether or not MGRS could act as a predictor for phobic and obsessive-compulsive behavior. This research followed on previous work in 1993 with a group of British volunteers that found MGRS scores to be significantly positively correlated with social fears, agoraphobic fears, fears of bodily injury, death and illness, fears of sexual and aggressive scenes, but not with fears of harmless animals.

Arindell et.al's 2003 research was conducted with a psychologically distressed sample ($N = 213$, 51 males and 162 females). Participants took four separate tests, including the MGRS, the Fear Questionnaire (FQ) (Marks, 1979), the Maudsley Obsession-Compulsive Inventory (MOCI) (Hodgson, 1977), and the Lie Scale portion of the Eysenck Personality Questionnaire-Revised (s-EPQ-R) (Eysenck, 1985). Results demonstrated that the MGRS five factors were individually positively correlated with the FQ's agoraphobia ($r = 0.26, p < 0.001$), fear of blood injury ($r = .22$ to $.28, p < 0.001$), and social fears ($r = .26$ to $.46, p < 0.001$). MGRS scores were positively correlated with the MOCI's obsessional checking ($r = 0.24$ to $0.40, p < 0.001$) and obsessional washing ($r = 0.15$ to $0.30, p < 0.01$).

The MGRS scale emerged as a suitable predictor for phobic and OCD behaviors,

with a particular emphasis on its ability to predict obsessive checking behavior more consistently than obsessive hand washing. The authors concluded that checking-behavior was likely affiliated with the masculine gender role attribute for “inflated responsibility” (p. 264), and therefore more positively correlated with MGRS symptoms. This study confirmed the utility MGRS in predicting particular types of emotional and psychological disorders.

MGRS and Anger

Men's expression of anger and hostility in the job setting may be related to gender role expectations, especially if they are required to act in a manner contrary to their masculine role. Jakupcak, Tull, and Roemer (Jakupcak, 2005) evaluated the utility of the MGRS scale, as well as scales for proneness to shame and fear of emotions, as predictors of anger and hostility. Male university students ($N = 204$) were tested utilizing the MGRS, the Affect Control Scale (ACS) (Williams, Chambless, & Aherns, 1997), the Male Role Norms Scale (MRNS) (Thompson, 1986) and the Test of Self-Conscious Affect-2 (TOSCA) (Tangney, 1989).

Results for MGRS were significantly correlated with all measures (ACS, $r = .29$, $p < .01$; MRNS, $r = .92$, $p < .01$; TOSCA, $r = .27$, $p < .01$). Utilizing hierarchical regression to determine if shame proneness and fear of emotions alone accounted for hostility, results indicated that masculinity reflected on the MRNS positively predicted variance associated with hostility ($\beta = .30$), $t(203) = 4.49$, $p < .01$. This study suggests that hostile behaviors and actions may be associated with job stress, as well as interpersonal conflicts. All tend to be related to MGRS, as well.

MGRS and Emotional Inexpressivity

In 2001, Holyoake (Holyoake, 2001) found that men nurses believed that “not caring” (p.88) demonstrated a male role-appropriate way of dealing with patients, in contrast to nursing culture’s expectation that nurses ‘care’. Similarly, Jakupcak, Tull, and Roemer (Jakupcak, 2005) found men’s fear of emotional expression emerged as the primary factor in anger expression ($\beta = .22$), $t(203) = 2.93$, $p < .01$. Men who find it difficult to express emotions, therefore, may resort to anger as a cover or decoy emotion for other feelings. Anger has been associated with MGRS. Emotional inexpressivity is a key element of MGRS, as well (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988).

In discussion, Jakupcak et.al note that male gender role expectations as expressed through masculinity, while significant, did not account for as much anger expression as did the men’s fear of emotions. The MGRS scale assesses fear of emotionality and thereby may be a useful tool in helping to predict expression of anger in a male population. This may hold particular applicability to men who work in female-dominated environments such as nursing, as the fear of emotional expression may be a potent factor in some men’s ability to carry out specific nursing behaviors.

MGRS and Job Satisfaction

With the preceding studies the concept of MGRS was shown to be appropriate in examining men for attitudes about their gender role; that elevated levels of MGRS appear to be related to physical stress and difficulty thinking clearly; that MGRS can act as a

predictor for specific emotional and psychological disorders; and that MGRS may be a predictor for expressions of anger. Expression of anger may occur inappropriately, for example, in response to gender role pressures, or be submerged by risk taking behaviors such as alcohol or drug abuse (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988). Anger may also be focused toward employment issues, as well, resulting in job misfit and dissatisfaction. In essence, these studies indicate that the presence of MGRS in men is associated with a host of potential social and behavioral difficulties.

The suggestion from this literature search is that employment factors intrinsic to nursing that stimulate or generate MGRS may indirectly lead to job dissatisfaction, as well as considerable personal distress. Men who hold more strict gender role conceptions may be especially at risk for dissatisfaction or distress. Conversely, men whose gender role beliefs are less strict or more fluid may be better able to adapt to the experiences encountered by men in nursing. Consequently, determining the presence of MGRS among men nurses, especially in relation to job satisfaction, may provide predictors for longevity in the profession as well as indicators of potential areas of distress.

Testing Instruments

Job Satisfaction: Mcloskey/Mueller Satisfaction Scale

The psychological and physical demands of nursing, as well as the female-dominated environment, create a unique employment atmosphere that is not duplicated in other professions. MGRS study findings cited previously suggest that internalized role expectations may affect men's responses through the behavioral and physiological spectrum. The absence of male-specific studies on nurse job satisfaction both constrains

and moderates possible avenues of exploration for this program of research.

Consequently, the selection of a research tool to assess male nurse job satisfaction must necessarily be circumspect until such time as a male nurse job satisfaction tool can be developed.

For this study, therefore, a broad-based widely used multidimensional questionnaire will be utilized to assess satisfaction. This questionnaire is the 31-item Mcloskey/Mueller Satisfaction Scale (MMSS) (Mueller, 1990). The MMSS is used to assess elements of autonomy, communication, financial rewards, promotion, co-worker relationships, supervision, workloads, and work demands. Its focus is on eight work factors: extrinsic rewards (salary, vacation); satisfaction with work schedules; balance between family and work; co-worker interactions; professional interactions; opportunities for professional advancement; recognition, and control and responsibility. There are four to five items per factor. Answers are scored on a 5-point Likert scale, ranging from 'very dissatisfied' to 'very satisfied'. Internal consistency was 0.89, with test-retest reliability for sub-scales ranging from 0.08 to 0.64. During development, the scale was correlated with an older reliable tool, the Job Diagnostic Survey (Hackman, 1975). Misener, Haddock, Gleaton, and Ajamieh (Misener, 1996) assessed the validity of this tool and concluded it was reliable as a measure of job satisfaction, as well as for use with differing cultural parameters.

MGRS: Masculine Gender Role Stress Scale

The conception of MGRS grew out of the concept of gender roles, specifically the male gender roles in our culture. Richard Eisler and Jay Skidmore (R. M. Eisler &

Skidmore, 1987) theorized that the socialization of masculine gender roles acted as a template for men's appraisal of the stress levels of specific situations. In effect, males who held more standardized or traditional ideas of "how a man should be" -- a strict conceptualization of masculinity, which included traits of competition for power and control, inhibited emotionality and stoicism, and sexual prowess -- might experience more stress in situations that challenge or negate those qualities. Perceived status, power, control, and sexual orientation then represent significant factors in the development of MGRS.

To test the theoretical aspects of the concept of MGRS, Eisler and Skidmore developed of a scale. Items were generated empirically using sentence completion to derive stressful attributes associated with manhood. Respondents were 87 male and 118 female psychology undergraduates. Based on the results, 105 items were written for the initial version of the MGRS scale, with each representing a potentially stress-generating circumstance for men. The items were then provided to 50 raters consisting of 12 psychology faculty and 38 psychology graduate students, who judged each item for the level of stress each might generate in men and in women.

Two selection criteria were generated from the ratings. First, items were retained only if they were rated significantly more stressful for men than women ($p < .01$, paired t -tests). This eliminated items that were equally stressful for men and women. Second, the mean stress rating for each item had to be in the middle to high range. By using the higher level stressor items, the authors indicated that the situation in question was appropriate for men as well as more stressful for men than women. From this ratings procedure, the 105 items were reduced to 66.

Preliminary validation tests were then conducted four times among 173 participants (male = 82, female = 91), in concert with the Personal Attributes Questionnaire (PAQ), (Spence, 1974), Siegel's Multidimensional Anger Inventory (MAI) (J. Siegel, 1986), and the State-Trait Anxiety Inventory (STAI) (Spielberger, 1983). In correlating and comparing the MGRS preliminary results with these known instruments allowed comparison between MGRS results and anger, masculinity, and anxiety profiles. As men tend to identify with the masculine role and women with the feminine role, item situations that threatened masculinity would be appraised more stressful by men than by women. Responses on the MGRS indicated that men scored significantly higher than women on the MGRS scale ($t = 3.82, p < .01$).

MGRS scores were not correlated with masculinity scores ($r = .08$), indicating that MGRS was largely separate from masculine identification. Therefore, a man's sense of how masculine he is will be separate from his perception of how well he fulfills his male gender role behaviors. Masculinity is differentiated from male gender roles. However, higher scores on the MGRS were positively correlated with anger ($r = .54, p < .01$) and anxiety ($r = .23, p < .05$) without state-trait differences. This reflects emotional distress initiated by the inability to conform to gender roles, as demonstrated through anger and anxiety.

The scale was further refined at this point, by eliminating items that were not at least moderately correlated with the total score ($r < .33$). This reduced the items from 66 to 43. Next, the resulting items were analyzed using a sample of 150 undergraduate men 17-25 years old. Factor analysis was utilized systematically to extract factors by principal component analysis. Each factor was expected to contain at least six loadings of

.30 or greater and at least three of .50 or greater. Eigen values were set at 1.50 for each factor (more conservative than the standard 1.0) allowing for stable factor extractions. Five primary factors were identified, each containing 7-9 items, with loadings from 0.33 to 0.70. At this point, 3 items were removed due to low factor loadings or incongruence. The MGRS scale then was stabilized at 40 items.

The five factors were: Factor 1, Physical Inadequacy: "Feeling that you are not in good physical condition" (loading of 0.62); Factor 2, Emotional Inexpressiveness: "Telling your spouse that you love him/her" (loading of 0.54); Factor 3, Subordination to Women: "Being outperformed at work by a woman" (loading of 0.69); Factor 4,, Intellectual Inferiority: "Having to ask for directions when you are lost" (loading of 0.64); Factor 5, Performance Failure: "Being unemployed" (loading of 0.70).

The scale, as completed, consisted of 40 items in five factors, each Likert scored. Eisler and Skidmore (p.134) indicated that the cognitive appraisal of a situation, that is, the process of generating an event's meaning, determines the emotional reaction to that situation. Gender role socialization consequently affects the cognitive appraisal an individual utilizes to understand a given situation. In effect, those men who scored higher on the MGRS utilized cognitive appraisal in concert with expected gender role expectations, and assessed given situations that challenged their male competence as more stressful.

The MGRS scale appears to be applicable outside of North America, as well. Van Well, Kolk & Arrindell (van Well, 2005) explored the utility of the Dutch translation of the MGRS and Feminine Gender Role Stress (FGRS) scales among the population of the Netherlands. Undergraduate university students ($N = 2,239$, representing 954 males and

1285 females) from multiple disciplines were participants in an online and paper study. The study utilized a survey called the daily hassles scale, the Personal Attributes Questionnaire (PAQ) (Spence, 1974), as well as MGRS questionnaires. Reliability as a measure of interconsistency of the MGRS was .90 as shown by Cronbach's alpha. The five factors were also shown to be satisfactory at Subordination to Women (.80), Performance Failure (.76), Physical Inferiority (.70), and Emotional Inexpressiveness and Intellectual Inferiority (.69 each). The authors point out that the lower alphas are appropriate if the mean inter-item correlation is taken into account. Construct validity was demonstrated by positive correlation to scores on the daily hassles scale ($r = .40, p < .001$) and the expected inverse correlation to the Masculinity scale of the PAQ ($r = -.21$).

Fit indices for the standardized root mean squared residual was .065 and for the root mean squared error of approximation was .064, which met the criteria for model fit. The authors concluded that the MGRS was appropriate for use among the Dutch. The use of this tool appears to also fit Leininger's Culture Care Model (Leininger, 1997) goal of diversity (of culture) and universality (of masculine response).

There are no other tools comparable to the MGRS scale. No population norms for MGRS levels could be found in the literature. However, as noted previously, elevated MGRS scores are correlated with anger, anxiety, and physiological distress.

Chapter Three

Methodology

This study utilized a male-specific tool, a general nursing tool, and demographic questionnaire to examine the interaction of MGRS, job satisfaction, and personal variables. Instruments were available online to participants who received a post card invitation to participate. Follow-up postcard reminders encouraged participation. Protections for privacy and human subjects were ensured. Analysis was performed utilizing the statistical software program SPSS 21.0.

Instruments and Sample

The MGRS Scale (R. M. Eisler & Skidmore, 1987) is a 40-item questionnaire that measures the respondent's appraisal of the threatening or stressful qualities of specific situations, in relation to his self-estimation of appropriate personal masculine behaviors. Responses are measured on a Likert Scale from 0 to 6 (*not at all* to *very stressful*). Responses are added across all items to obtain a composite score of 0-240. Higher scores represent elevated MGRS. Five MGRS factor scores can be extracted, which evaluate physical, emotional, intellectual, performance, and subordination issues. Reported test-retest reliability over 2 weeks was high ($r = .93$) with good internal consistency ($\alpha = .90$) (R. M. Eisler, Skidmore, J.R., & Ward, C.H., 1988). Eisler cited studies that showed positive correlations between scores on this instrument and respondent's reports of anxiety, anger, and risk-taking behaviors. Permission for use of the MGRS Scale in this study was secured from originator Jay Skidmore. (See Appendix A.)

Job satisfaction was measured using the Mcloskey/Mueller Satisfaction Scale

(MMSS), a 31-item Likert-scored paper and pencil tool (Mueller, 1990). Reported internal consistency was 0.89, with test-retest reliability for sub-scales ranging from 0.08 to 0.64. During development, the scale was positively correlated with an older reliable tool, the Job Diagnostic Survey (Hackman, 1975). Permission for use of this instrument was secured (see Appendix B).

Demographic data was collected using a seven item questionnaire. Data to be collected included participant's age, educational level (defined as LPN, RN, BSN, MSN, Post-Grad Certificate, or PhD/DNS/DNP), employment setting (hospital department, clinic, community), marital status, ethnicity, and sexual preference (Appendix C).

A sample of men nurses was recruited by mail. The population was all licensed men nurses in Missouri supplied by the Missouri State Board of Nursing statistical services. Participants represented urban and rural nurses, as well as a broad range of ages and professional experience.

Procedures

The Missouri State Board of Nursing (MSBON) was contacted by email correspondence through their website, and a request placed for purchase of a mailing list roster of men nurses living and currently employed in the state. MSBON indicated that they did not separate listings by gender. Consequently, the sum total of all nurses' mailing information was supplied, approximately 105,000 nurses.

This researcher separated men from women utilizing gender normed first names: "Cheryl", "Lisa", and "Tonisha" were determined to be female and were excluded from the mailing. "Michael", "Jimmy", and "Clevon" were determined to be male. In

instances where the first name was gender neutral (“Chris”, “Dana”, “Yu”), the middle name was utilized for gender norming. Names that could not be gendered were excluded ($N = 126$). This resulted in a list comprising all men nurses registered in Missouri ($N = 7842$). Review indicated that some listed other states as their residence, and these were also deleted ($N = 3115$), leaving a total of 4528 men nurses who were contacted. Approximately 1100 cards were returned as undeliverable, so the approximate number of men nurses contacted was 3400.

The mailing consisted of a letter (Appendix D) requesting participation in a male-nurse only online survey. A web address was provided. The card directed recipients to use a computer to access a webpage that provided a cover letter, information about the study, its purpose, benefits, risk, protection of confidentiality, and a statement of informed consent. Participants were asked to click a box that stated they agreed to informed consent before proceeding to the questionnaires. Clicking through acted as agreement to informed consent.

After clicking the agreement box, the survey opened on a new page at www.surveymonkey.com to the two instruments and demographic questions. Participants were able to complete the forms in approximately 10 minutes. At the conclusion of the questionnaires, a link was provided so that participants could request email information on the outcome of the study when completed. All responses were anonymous and participants cannot be identified by any element of the questionnaires. Email addresses were not linked or linkable to any specific set of responses. ISP address collection was turned off by the researcher. Respondents were asked to access the questionnaires only one time to avoid duplicate responses. Six weeks after the initial request, a reminder

postcard requesting completion of the questionnaires was mailed. Four weeks after that, the researcher utilized returned letters to extract new forwarding addresses for approximately 800 nurses, and a request post card was mailed to these.

Privacy, Participant Rights, and Informed Consent

The researcher made no effort to identify the participant by means of their computer's ISP address. Email addresses, for participants who requested study results, were not linked or traceable to any specific questionnaire responses. Institutional Review Board approval was sought and obtained from Duquesne University Institutional Review Board prior to commencing the study. Respondent data did not include identifiers or other information that could be used to identify any individual participant, and only aggregate results are reported as group information. Survey data is stored in the investigator's computer and storage media, and protected by password security procedures. There was little risk beyond normal daily activity to individuals for participating, and participation required no more than 10 minutes to complete. Individual benefit for participation may have included satisfaction at aiding nursing research, self-expression, and insight into personal attitudes and conviction. No one who received or read an invitation was required or compelled to participate, and any invitee may have declined to participate without repercussion. Participants were informed that they could stop participation at any time without penalty. Opening the provided internet address, clicking the yes box, and proceeding to the questionnaires acted as agreement to informed consent.

Limitations

Return rates for paper questionnaires are typically low (Polit, 2004), and may depend on structural factors unrelated to the topic itself (D. Dillman, Carley-Baxter, L., 2000). Web-based sampling is relatively new, and response rates appear to depend significantly on factors related to ease of computer use, visual appearance, and the user's skill with their computer (D. Dillman, Tortora, R., Conradt, J., & Bowker, D., 1998). To accommodate the possibility of a lower response rate, an oversampling of 3000 participant mailings was generated, six times the desired number of participants, in order to secure a representative response. This strategy, however, was ineffective.

Limiting the respondents to one state may produce cohort or regional results that do not generalize to the larger population of men in nursing; future studies may compare results across states or countries for a broader sampling. Given the temporal nature of the survey, results may reflect only men nurses' current experiences and not accurately represent changes that occur over time. The possibility of individuals repeating the survey or providing spurious information exists although, as in traditional paper surveys, the percentage of this type of obstructive behavior may be at an insignificant level. The study is limited to those with access to a computer and/or computer savvy to complete the questionnaire. It is believed that this limitation is small in that most nurses today take part in electronic medical records at work thus demonstrating at least minimal computer skills.

Analysis

Data for each participant was entered into the statistics software program SPSS 21.0, then submitted to appropriate study as indicated. For the first research question

(*What is the incidence of MGRS among men nurses in Missouri?*), descriptive statistics including frequencies and means were determined. Each of the five MGRS factors were analyzed separately. In addition, comparison and correlation of demographic data with both the sum MGRS scores and the five factors was performed using non-parametric tests Spearman's *rho* and Kendall's *tau b* with no assumption of normal distribution.

For the second research question, (*What is the correlation between MGRS and job satisfaction?*), analysis was by utilization of Spearman's *rho* and Kendall's *tau b*. Likert responses are summarized in central tendency by median rather than mean (S. Siegel, & Castellan, Jr., J. , 1988). Results indicated the relationships between MGRS and job satisfaction. When correlating ordinal data, such as MGRS factor scores in relation to job satisfaction, Spearman's *rho* (Wendorf, 2004) was used. Independent samples *t*-test was used to compare the variable job satisfaction, transformed into a dichotomous variable (satisfied/unsatisfied), to median scores on each of the independent MGRS factors, seeking to discover any relationship between job satisfaction and factors of physical inadequacy, emotional inexpressiveness, subordination to women, intellectual inferiority, and performance failure.

The third research question (*Is there a difference in level of MGRS and job satisfaction by highest level of education in nursing?*) This final analysis used both the MGRS and MMSS scores, in comparison to level of education to determine interactions among these variables. Summed Likert responses were treated as interval data to measure a latent variable, and if compared to an ordinal variable (education level) then analysis of variance (ANOVA) may be applied (French, 2002). Because MANOVA requires nominal or dichotomous variables in application of Hotelling's *T* (dichotomous independent

variable with multiple dependent variables), one-way MANOVA (multi-level nominal independent variable, and multiple dependent variables), or factorial MANOVA (multiple nominal independent variables, and multiple dependent variables) according to Wendorf (Wendorf, 2004), it would have been inappropriate to use for this final test. Kruskal-Wallis H analysis of variance may be used to compare three or more groups of data (MGRS, job satisfaction, education level) that are not assumed to be normally distributed (Elliot, 2007), so are utilized here with possible loss of power compared to ANOVA.

Chapter 4

Data Analysis

Introduction

This chapter represents the outcome of statistical analysis of the data derived from a survey submitted to a sample population of men nurses. The Masculine Gender Role Stress (MGRS) survey, and the Mcloskey-Mueller Satisfaction Scale (MMSS) were utilized, along with demographic information. Data obtained from the surveys and demographic information were submitted to statistical analysis, using non-parametric tests and the statistical program SPSS 21.0. The purpose of this study was to determine if there were relationships between MGRS, job satisfaction, and demographic factors. Findings from the data analysis will be presented in this chapter. There is a brief description of the comments provided by participants, as well.

Participants

Men nurses residing in Missouri were contacted by letter and asked to participate in an online set of surveys. Over 3100 letters were sent to active addresses, with a follow-up postcard sent 6 weeks later. An additional contact postcard was sent to approximately 800 addresses which were found on original mail that was returned. Recipients were asked to retrieve the information on the internet at a designated Survey Monkey website. A total of 105 respondents opened the site online and completed at least a portion of the process, and 88 completed the process with occasional skipped questions reflecting a 2.8% response rate.

The survey site consisted of a statement of informed consent, a demographics

section, the Masculine Gender Role Stress survey, and the Mueller-Mcloskey Satisfaction Scale questionnaire. Utilizing an estimated effect size of .30 to .40 with an alpha of .05 two-tailed, at a power of .80, a sample of 85 ($r = .30$) or 46 ($r = .40$) participants was needed (Cohen, 1988; p. 102) assuming randomness in the sample. Sufficient participants were included to fit this criteria.

Characteristics of the Participants

Participant demographic characteristics were retrieved using multiple choice and fill-in questions, requesting age, years as a nurse, degree, marital status, sexual preference, and field of employment within nursing. A few participants skipped individual questions, as noted.

Table 4.1
Participant Age and Years in Nursing

	<u>Age in Years</u>	<u>Years as a Nurse</u>
N Valid	87	86
Answers		
Missing	1	2
Mean (SD)	50.7(11.4)	22.51(11.7)
Range	27-70	1-27

Table 4.2
Degree Level

	<u>Frequency</u>	<u>Percent of Total</u>
LPN	13	14.8
RN/ASN	14	15.9
BSN	14	15.9
MSN	36	40.9
Post-Graduate	5	5.7
DNP/DNS	3	3.4
PhD	3	3.4
Total	88	100.0

Table 4.1 indicates that the Mean age of the participants was 50.7 years ($SD = 11.4$, range 27-70). The Mean of years as a nurse was 22.51 ($SD = 11.7$, range 1-27). Table 4.2 indicates that the majority of participants, 40.9%, held a Master's degree. The breakdown between undergraduate and graduate degrees was 46.6 percent held LPN, RN, or BSN undergraduate degrees, and 53.4 percent holding graduate to doctoral degrees.

Table 4.3
Marital Status

	<u>Frequency</u>	<u>Percent</u>	<u>Valid Percent</u>
Single, divorced, widowed	12	13.6	14.0
Married, partnered, living together	74	84.1	86.0
Total	86	97.7	100.0
Missing	2	2.3	
Total	88	100.0	

Table 4.3 indicates that the majority of participants who answered the question ($N = 86$) were partnered (86 percent), and 14 percent were single.

Table 4.4
Sexual Preference

	<u>Frequency</u>	<u>Percent/Valid Percent</u>
Women	67	76.2
Men	20	22.7
Both	1	1.1
Total	88	100.0

Table 4.4 indicates the sexual preferences of participants. Sixty-seven participants (76 percent) preferred female partners. Twenty participants (22.7 percent)

preferred male partners. One participant (1.1 percent of the total) expressed preference for both male and female partners.

Table 4.5

Ethnicity

	<u>Frequency</u>	<u>Percent/Valid Percent</u>
African American	2	2.3
Asian or Chinese	1	1.1
European or Caucasian	80	90.9
Hispanic or Latino	2	2.3
Multiple origin	2	2.3
Prefer not to answer	1	1.1
Total	88	100.0

Table 4.5 indicates the Ethnicity of the respondents, showing that 90.9% ($N = 80$) identified as of European or Caucasian origin. Less than 3% each identified origin in another group ($N = 2$ African American; $N = 1$ Asian or Chinese; $N = 2$ Hispanic or Latino; $N = 2$ Multiple origin; $N = 1$, no answer).

Table 4.6

Field of Employment

	<u>Frequency</u>	<u>Percent/Valid Percent</u>
Administration	1	1.1
Anesthesia	17	19.3
Cardiac surgery	1	1.1
Cardiology	5	5.7
Case management	1	1.1
Educator	1	1.1
Emergency room	13	14.8
Faculty	2	2.3
Family Practice	9	10.2
Gastroenterology	1	1.1

General Surgery	1	1.1
Geriatrics	1	1.1
Home health	4	4.5
Hospice	1	1.1
Hospital associate	1	1.1
Hospitalist	1	1.1
ICU	2	2.3
Informatics	1	1.1
Internal Medicine	1	1.1
Med/Surg and Long Term	1	1.1
Medical/Surgical	7	8.0
Neonatal	1	1.1
Oncology	1	1.1
Orthopedics	2	2.3
Pain Management	1	1.1
Pediatrics	1	1.1
Performance Improvement	1	1.1
Plasmapheresis	1	1.1
Psychology	2	2.3
Psychiatry (dispensing)	1	1.1
Rapid Response	1	1.1
Skilled Nursing	1	1.1
Surgery	2	2.3
Total	88	100.0

Table 4.6 demonstrates that participants employed in Nurse Anesthesia were 19.3% of respondents ($N = 17$), with Emergency Room employment second highest at 14.8% ($N = 9$). Family practice was the third most common area of employment at 10.2% ($N = 9$), with Medical/Surgical ranked fourth with 8% ($N = 7$). Cardiology ranked fifth at 5.7% ($N = 5$), and Home Health sixth at 4.5% ($N = 4$). The remaining twenty seven categories of employment ranked 2.3% each or less, representing one or two respondents each.

Research Questions

Analysis of each research question was performed utilizing SPSS 21.0 software program. Analysis encompassed several layers of investigation for each question.

Research Question 1: *What is the incidence of MGRS among men nurses?*

Utilizing Cosenzo et al.'s (Cosenzo, 2004) methodology, sum of scores across respondents was performed. Score totals below 76 represent low levels of MGRS. Scores above 95 indicate active MGRS. Scores between 76 and 95 therefore represent moderate levels.

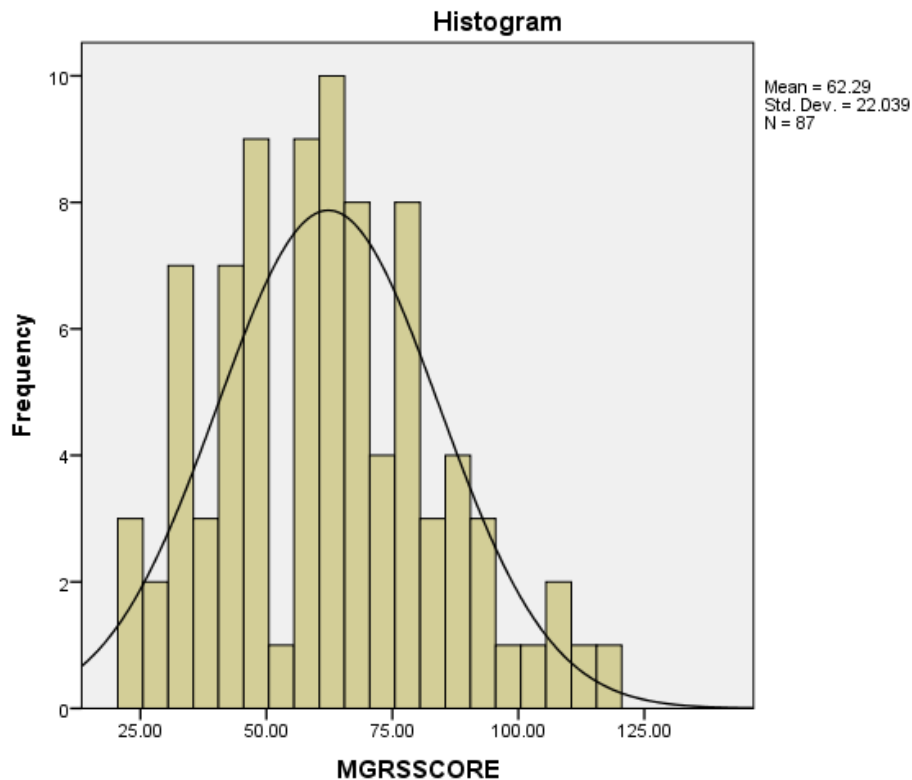


Figure 4.1
Distribution of MGRS Scores

Sums of respondent scores indicated that 6.6% ($N = 6$) demonstrated high levels of MGRS. Moderate MGRS was shown by 20.5% ($N = 18$) of participants. The majority, 71.8% of respondents ($N = 63$) tested low in MGRS. The mean score of all participants

was 62.29 ($SD = 22.04$, $N = 87$), a score indicating low MGRS. Results were normally distributed. High MGRS scores were not significantly correlated with age, years as a nurse, marital status, degree level, or sexual preference.

Across the five MGRS factors of physical inadequacy, emotional inexpressiveness, subordination to women, intellectual inadequacy, and ability to perform, correlation utilizing Kendall's τb and Spearman's ρ was performed. No significant correlations were found among the five factors and demographic elements. However, several individual items of significance were found when compared to differing factors: age (positively correlated with question about *level of discomfort having a man place his arm around one's shoulder*, $r(86) = .201$, $p = .018$; years as a nurse (positive correlation with *level of discomfort having a man place his arm around one's shoulder*, $r(85) = .227$, $p = .007$; degree (negative correlation with *concern about lack of money*, $r(85) = -.175$, $p = .033$. Marital status was positively correlated with two questions, *concern about one's wife having to work*, $r(83) = .241$, $p = .016$; and *comforting a man who was distressed*, $r(85) = .231$, $p = .022$.

Research Question 2: *What is the correlation between MGRS and job satisfaction as indicated by MMSS scores?* MMSS scores were summed across all participants, resulting in a total satisfaction score for each participant. Scores were based on the Likert Scale used on the survey, with 1 = very dissatisfied, 2 = dissatisfied, 3 = satisfied, and 4 = very satisfied. There was also a "not applicable" condition, which participants utilized when the question asked did not apply to their situation. If a participant selected a "not applicable" answer, that item was omitted from analysis. The mean of scores represented a state of satisfaction across all factors ($M = 3.041$, $SD =$

.429, range = 1.94, $N = 87$).

Table 4.7
Job Satisfaction by Item

	<u>N</u>	<u>Mean</u>	<u>Std. Dev.</u>
Salary	85	2.91	.781
Vacation	86	3.08	.829
Flexibility of schedule	86	3.00	.958
Work hours	82	3.18	.650
Flexibility of work	77	3.13	.714
Ability to work days	67	3.36	.644
Ability to work part time	53	3.09	.658
Weekends off	74	3.26	.741
Flexibility on weekends	58	3.31	.730
Compensation for weekends	51	3.04	.747
Maternity leave	11	3.27	.647
Childcare	18	2.44	.511
Relationship with head nurse	57	3.16	.751
Acceptance by peers	81	3.19	.654
Acceptance by physicians	78	3.15	.626
Care methods utilized at facility	66	3.20	.613
Social relations at work	82	3.20	.508
Social relations after work	77	3.03	.537
Interaction with other disciplines	79	3.10	.568
Interactions with faculty	55	3.07	.573
Ability to join committees	65	3.14	.583
Control over work setting	78	2.82	.698
Career advancement	73	2.90	.690
Recognition by superiors	74	3.08	.678
Recognition by peers	83	3.17	.559
Positive encouragement	76	2.99	.643
Ability to do nursing research	50	3.02	.622
Ability to write or publish	41	2.98	.651
Ability to affect management responses	86	3.15	.604
Control over work conditions	75	2.97	.592
Effect on organization decisions	<u>78</u>	<u>2.55</u>	<u>.878</u>
N/Mean/SD	88	3.04	.429

Table 4.7 shows a breakdown of results for each question. The indication is that

respondents are generally satisfied with their working condition.

MGRS and MMSS scores were submitted to non-parametric Kendall's *tau b* and Spearman's *rho*. An inverse relationship was found between MMSS level and MGRS level, indicating that as MGRS level increased, MMSS level decreased. However, this relationship was not significant (Kendall's $p = .115$; Spearman's $p = .116$, two tailed).

Table 4.8
Correlation of MMSS and MGRS Scores

			<u>MMSS Level</u>	<u>MGRS Level</u>
Kendall's <i>tau_b</i>	MMSS Level	Correlation Coefficient	1.000	-.116
		Sig. (2-tailed)		.115
		N	87	87
	MGRS Level	Correlation Coefficient	-.116	1.000
		Sig. (2-tailed)	.115	
		N	87	87
Spearman's <i>rho</i>	MMSS Level	Correlation Coefficient	1.000	-.170
		Sig. (2-tailed)		.116
		N	87	87
	MGRS Level	Correlation Coefficient	-.170	1.000
		Sig. (2-tailed)	.116	
		N	87	87

Research Question 3: *Is there a difference in the level of MGRS and job satisfaction by highest level of education in nurse?* When submitted to analysis utilizing Kruskal-Wallis H , no significant variance was found for job satisfaction ($p = .748$) or MGRS level ($p = .183$).

Table 4.9

Difference in Levels of MGRS and Job Satisfaction by Education Level

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of AVERSATISF is the same across categories of DEGREE.	Independent-Samples Kruskal-Wallis Test	.748	Retain the null hypothesis.
2	The distribution of MGRSSCORE is the same across categories of DEGREE.	Independent-Samples Kruskal-Wallis Test	.183	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

However, utilizing Spearman's *rho*, it was found incidentally that MMSS satisfaction scores correlated positively with years in nursing ($r(84) = .215, p = .048$) and marital status ($r(84) = .236, p = .03$). MGRS scores showed no significant correlations with any of these factors.

Incidental Comments: Twenty two of the respondents made a closing comment at the end of the survey. Several of the comments were simple thanks for the opportunity to take the survey. Others explained their answers or rationale for answering a certain way, or clarified their personal situation. Some suggested improvements, corrections, other ideas. A few expressed dismay at the questions or survey itself. There was no significant correlation between the participants who commented and their MGRS or MMSS scores. Table 4.9 shows all the comments, grouped into the four types of responses.

Table 4.10
Comments

Explanation or Rationale

I work off site of the hospital in centralized telemetry. No pt contact. We take orders & get telemetry on the pt.

Some of the 0 replies meant, don't care, never a problem or LOL!

My answers are based on my last job as a CRNA. I am not currently working in health care and just starting to enjoy life again.

Several of the initial questions did not allow for n/a as I have never been asked or been exposed to the situation described.

I am a Nurse Anesthetist, as are many of the men who are nurses in Missouri. Much of this survey does not apply very well to our work setting/situation.

How many years worked in nursing" or "How many years worked as a nurse" ? My highest level of nursing education is "Diploma in Nursing"

Personal Clarification

Divorced male, 2 grown children, identifies as gay. have female supervisor. feel discriminated against many times.

Curious about personal questions. Some of us are comfortable with who we are and what we have chosen for a career path.

I thought it was interesting the survey did not ask corollary questions that would allow the researchers to determine whether it was the activity (ie losing a game) or the gender of the individual (male vs female). For me personally many of the activities are equally stressful regardless of the gender of the person involved.

As a male nurse, I do run across clients who do not "believe" men should be nurses. Among these clients are feminists who have a double standard, or a belief in equality of the sexes, but are against male nurses. It is also a regular happening to be chewed out by clients who believe that it is okay to devalue and degrade me since I am a male nurse. Don't get me wrong, there are good days in this profession, however, even at work I typically run across being out of work for months due to sexism and prejudice.

I work in preventative care / chronic disease management as an adult NP doing home

visits. I don't work with a collaborating physician or any nursing colleagues, so some of the questions at the end didn't apply directly; but at times i was able to extrapolate how i would feel / react easily.

Improvements, Corrections, or Other Ideas

Seems like demographics such as current position would be relevant. I'm the director of my area

Please note that Question 23, in the last half, has the word "career" spelled incorrectly. Thank you for this opportunity.

I was surprised you did not ask me to rate if I feel I am treated differently, given special preference, ever been involved in a sexual harrassment suit, ever been in an uncomfortable position (doing a female cath, pelvic, etc). I believe I have witnessed men "getting away with" some issues or practices that women on the same unit would be called out on. Do you think nursing has gained an increase in salary, recognition because of men? Do you thing men can be as "caring" as a female, esp in stressful situations? Thanks.

Please send results to xxxxxxxx@gmail.com. Their should have been a non applicable spot on the first part of the survey...and maybe a sexual harassment s Question in here as I was sexually harassed by female employee at my facility..thanks

My comments are from the perspective of an ACNP working in the SICU. We do swing shifts 2weeks days, 2weeks nights, every other weekend. Salary. My group is 14 NP's. We cover 55% of a 44 bed ICU 24/7. I enjoyed nursing, the compensation was adequate, but I wanted more challenge. NP's make too little & have drastically more challenges. RN's need few changes, NP's need drastic changes.

Dismay

Some of the questions appeared to be very inappropriate, I wonder what correlations we're trying to draw here? Please reconsider what you're doing if there's a sexism angle going on with this research... "Men nurses" do the job, but we have a tendency to do it a little differently, not better, not worse, but different.

I'm sorry to say this, but your survey is intrusive, obnoxious, poorly written, and fails to cater to those of us with advanced practice degrees that aren't essentially floor nurses. Your verbiage is unprofessional and your choice of post card is asinine. I find it unbelievable that a Masters level candidate for Doctoral Studies would have produced work that I would find unacceptable at the Baccalaureate level.

I don't really know what kind of answer you expected on a question like #6 - amount of stress caused by not being able to find a sexual partner. I find it very unfortunate/disturbing that there is no N/A response to this question. I know that

people have all sorts of lifestyles and I can't make that decision for them, but I am married and that makes my answer to this question be that the question itself doesn't apply to me since I ALWAYS have a sexual partner.

Appreciation

Thank you for the opportunity.

Thanks for this opportunity!

MGRS Survey Interconsistency Test

In order to evaluate interconsistency of the MGRS survey tool, the outcome was submitted to scale testing for reliability. Cronbach's alpha was found to be .907 overall. The five factors were also shown to be satisfactory at Subordination to Women (.82), Performance Failure (.69), Physical Inferiority (.73), Emotional Inexpressiveness (.75) and Intellectual Inferiority (.77). This is consistent with results obtained by van Well, Kolk & Arrindell (van Well 2005), and indicates the survey remains reliable.

Summary

This study utilized two survey tools, the Masculine Gender Role Stress scale and the Mclosky/Mueller Satisfaction Scale, and a demographics section. Together, these tools were utilized to collect data and analyze the relationships between the three elements. The analysis consisted of descriptive, frequencies, and non parametric correlation by Spearman's *rho* and Kruskal-Wallis-*H* utilizing SPSS 21.0 statistical software. Cronbach's alpha was obtained utilizing scale analysis.

Findings included non significant inverse correlation between MGRS scores and

job satisfaction on the MMSS, high levels of MGRS among 6.6% of the respondents with the mean of MGRS at a low level in this sample, and that degree level was not correlated with either MGRS or MMSS scores. Incidental findings included a positive correlation between job satisfaction and years worked in nursing. Reliability by Cronbach's alpha was .907. In addition, a selection of comments provided by participants fell within five categories of explanation, personal clarification, improvements, dismay, and appreciation.

Chapter 5

Discussion of Findings

Introduction

This study examined the existence of Masculine Gender Role Stress in relation to job satisfaction among men nurses, with data collected from men nurses in Missouri during 2012 to 2013. Two established survey tools were utilized, the MGRS scale and the Mueller-Mcloskey Satisfaction Scale, along with a brief demographic questionnaire. One hundred and five individuals responded to the surveys, and 88 participants completed both surveys. Data was analyzed utilizing non parametric tests including Spearman's *rho* and Kendall's *tau b* by way of SPSS 21.0 statistical package. Results were delineated in the previous chapter. A discussion of those results follows.

Discussion of Demographics

Although over 85% of the original mailings sent to this population were to LPNs and RNs, the majority of respondents to the surveys were masters-prepared (40.9%). In addition, nurse anesthetists comprised the highest responses by discipline within nursing (19.3%). The nurse anesthesia discipline has a higher level of men nurses in it than any other nursing discipline, 41.1% nationwide, (U.S. Department of Health and Human Services, 2010). It is clear that the responses to this survey represents primarily higher degreed individuals, concentrated in disciplines in which percentages of men is higher overall.

The reigning dilemma here is why LPN and RN response levels did not reflect their representation within nursing itself. This issue was expressed by another researcher

during a personal conversation in 2012. He had conducted an online survey and similarly found that the majority of respondents were graduate level. An initial assumption was that masters-prepared nurses are likely to understand the importance of research to the development of the profession as a consequence of their education. As an outcome, masters-prepared may be more likely respond to survey requests than nurses whose education did not stress the value of research in relation to skill acquisition. An alternative interpretation may be that non-graduate nurses may lack the time, inclination, or sense of inclusion within the profession to consider participating in research surveys. Some potential participants may have simply discarded the mailed requests as junk mail, without review.

Alternatively, had potential respondents' email addresses been available, and a click-through link to the website been provided, results may have been higher and delivered more rapidly. The State Board of Nursing in Missouri did not collect nor provide email addresses, so that potential means of contact was unavailable for this study.

Ethnicity of respondents was greater than 90% Caucasian/European, which reduces the applicability of results to men nurses of other ethnicities. It is possible, as well, that non Caucasian/European men are not well-represented within nursing itself, and that therefore their response rate would be low in any situation. Ethnic differences, therefore, did not figure significantly in the results of this study.

Marital status reports indicated that 86% of the respondents who answered the question were married, partnered or living together. This is higher than the general population of men currently married or cohabiting, 55% (U.S. Department of Health and Human Services, 2006). Sexual preference varied considerably from statistical averages,

as well. Men who preferred male partners in this survey, 22.7%, was significantly higher than the general population at 1.7% (U.S. Department of Health and Human Services, 2006). The National Gay and Lesbian Task Force estimates that 3-8% of men are homosexual (Robison, 2002), also significantly lower than the self report from this survey. There is a widespread assumption that most men nurses are gay (Harding, 2007), but there have been no prior studies which have quantified the percentage of men nurses who prefer male partners. The current survey indicates that roughly 1 out of every 4 men nurses who participated were gay.

The mean age of participants was 50.7 years, reflecting the general aging of the nursing population overall (Spratley, 2002). Although participants' years working as a nurse varied from 1 to 27 years, the mean was 22.5 years within the profession. Once again, this is a reflection of the aging of the nurse population. The indication is that men are entering nursing at somewhat higher rates than even a decade ago, (U.S. Department of Health and Human Services, 2010), but the ages of entry are 2-5 years older than women entering the discipline.

Discussion of Results of Research Question 1

There were several elements in Research Question 1, *What is the incidence of MGRS among men nurses?* The primary question was answered with 6.6% of respondents showing high levels of MGRS, and an additional 20.5 % demonstrated moderate levels. However, 71.8% tested low in MGRS, and the mean score of all participants was 62.29, an overall low MGRS level. There was no significant correlation of total MGRS score with age, years as a nurse, marital status or sexual preference.

The finding that levels of MGRS are low among men nurses in this study is an interesting outcome. Men whose masculine identity is under duress typically experience elevated levels of MGRS (R. M. Eisler, & Blalock, J.A., 1991); and working in nursing has been demonstrated to generate distress, dissatisfaction, and higher rates of leaving the profession among men than women nurses (Deane, 2002; NewsRx.com, 2002; Pommerantz, 2002). However, participants averaged two decades of work as a nurse in this sample, suggesting the possibility that men who were afflicted with MGRS may have been among the numbers who left the profession through choice or disciplinary action (Evangelista, 2008) before achieving higher education or working for years in the business.

An unexpected result was found in examining the five MGRS factors (physical inadequacy, emotional inexpressiveness, subordination to women, intellectual inadequacy, and ability to perform) in correlation with sexual preference, but not in other demographic elements. Two of the 8 questions in both factors of intellectual inadequacy and ability to perform triggered significantly higher levels of distress in men who preferred male partners, than in men who preferred female partners. Although this is a very small sample, the results are suggestive of the importance of intellectual and performance skills in men who prefer male partners. Subordination to women did not result in similar responses, and these men were also not concerned with physical adequacy or emotional expressiveness. As tantalizing as this may be in helping to understand gay men nurses, significant responses to two questions out of eight in two factors may not be significant in the overall picture.

Discussion of Results of Research Question 2

The question *What is the correlation between MGRS and job satisfaction as indicated by MMSS scores?* led to the outcome that the participants were generally “satisfied” with their employment across all factors. Of the items respondents were most satisfied with, ability to work days if desired, rated highest (mean score of 3.36), with 67 respondents answering that question. The question dealing with satisfaction over maternity leave scored second highest, but only 11 participants answered this question. The third highest mean score was 3.26, given to weekends off offered by their employer, answered by 74 respondents. Having one’s weekends off and receiving that time from their employer, appeared to be both a valued factor to most participants and one which they experienced. Quality maternity leave time was very important to a small number of participants, or was available to fewer participants. Given the mean age of participants at 50.7 years, maternity leave for their wives or cohabiting partner may not be an important consideration for the majority of participants.

Eighteen participants found their institutions’ provision of childcare to be an area of dissatisfaction, with a mean score of 2.44. Once again, this is a small number of participants commenting on this item, less than one-fourth of the sample. Given that provision of child care may not be a high priority for men (their wives or partners, or their spouse’s employers, may handle that element). It’s also possible that participant employers may not offer child care services, or that participants did not require those services or feel they were important.

Seventy eight of 88 participants were dissatisfied (mean score 2.55) with their

ability to affect organization decisions. This employment situation was the lowest satisfaction rating affecting the highest number of participants. The dissatisfaction with this factor is reflective of a sense of lack of control over one's employment situation, or an experience of being "unheard" by organizational higher-ups. Whereas the participants may be satisfied with their ability to work day schedules rather than being stuck on an unwanted night shift, that satisfaction is over personal time and does not bear an effect on the organization itself.

Job satisfaction as measured by the MMSS was not significantly related to MGRS levels, although a weak inverse relationship was found. This outcome suggests that as job satisfaction decreases, MGRS worsens, or that lower levels of MGRS are related to increasing job satisfaction. This does not clarify if job dissatisfaction somehow triggers MGRS, or if the presence of MGRS decreases job satisfaction. However, since the inverse relationship was non significant, it is also possible that there is no relationship between job satisfaction and MGRS in this sample.

Discussion of Research Question 3

The third Research Question, *Is there a difference in the levels of MGRS and job satisfaction by highest level of education in nursing?* yielded no significant differences based on level of education. However, incidentally it was found that job satisfaction positively correlated with years in nursing and with marital status. In effect, the longer a participant worked in nursing, the greater his job satisfaction overall. This result appears commonsensical, that if one stays within a profession for years, one is likely to be satisfied with one's employment.

Additionally, the positive correlation with marital status indicates that men who are married, partnered, or living together express greater levels of nursing job satisfaction than single, widowed or divorced men. This result mirrors prior studies that found married men expressed greater employment satisfaction than unmarried men (Adams, 2000; Busier, 2000). The reason this correlation occurs has not been studied, but marriage for men has been associated with benefits including better income, health, and satisfaction than unmarried men (Steinhauer, 1995). This study echoes previous research on that factor.

Discussion of Incidental Comment Findings

The comments provided at the end of the survey by 22 of the respondents fell into five major categories, an explanation or rationale for answers to questions (6 instances); clarification of personal information (5); improvements, corrections, or ideas for studies (5); dismay at an element of the survey (3); and appreciation (2). The longest and most detailed comments fell into three categories, personal clarification; improvements, corrections or other ideas; and dismay.

Respondents who provided personal clarification ventured into areas not associated with this particular study, including the one who stated that *I do run across clients who do not “believe” men should be nurses... (clients) believe that it is okay to devalue and degrade me since I am a male nurse.* Another who identified having a female supervisor stated *feel discriminated against many times.*

One respondent who provided improvement, correction or ideas expressed surprise that the survey did not ask him to *rate if I feel I am treated differently, given*

special preference, involved in a sexual harassment suit, ever been in a uncomfortable positions (doing a female cath, pelvic, etc). He added *I believe I have witnessed men “getting away with” some issues or practices that women on the same unit would be called out on.*

These comments ventured into areas that this study was not designed to explore. However, but comments such as these indicate that for some men nurses, there is an underlying discomfort with their position within the profession. Interestingly, the respondent who expressed concern about being *in an uncomfortable position (doing a female cath, pelvic, etc)* touched on an area that has been discussed in the literature for almost two decades (Gaskin, 1995; Hawke, 1998) – the presence of men nurses in domains historically restricted to women nurses. Feeling uncomfortable while doing an intimate exam or treatment on a person of the opposite sex is not restricted to men nurses, since physicians experience the same effect and historically learned to manage their discomfort by performing their first pelvics on women anesthetized for other surgery (Wolfberg, 2007). However, that this effect has become an issue for men nurses is an important if often overlooked situation.

There were three comments, filed under the dismay category, which were critical of the survey itself. The strongest of these described the survey as *intrusive obnoxious, poorly written...unprofessional...asinine*. It is likely that the respondent believed that both surveys were written by this researcher, rather than being independently developed. The vehemence with which the respondent commented, however, suggests that questions in the surveys touched on sensitive areas that prompted an angry-appearing response.

In addition, approximately twenty participants requested a copy of the study when

it was completed. These requests were not linked to the survey responses, so no other data is available on those requestors.

Discussion of Findings in Relation to Theory

The theoretical basis of this study was Role Theory. The theory suggests that our actions and behaviors are guided by expectations: those we personally hold, and those held by other people. Role expectations are both ubiquitous and predictive, that once a person is defined by their role, their future behavior within that role will be predictable. One embraces one's role, and may experience *role conflict* or *role strain* when expected to perform in ways contrary to one's role. Masculine Gender Role Stress, an outcome of being compelled to perform outside one's socialized male gender role expectations, is a specialized version of role strain.

In role theory, the expectation is that as role strain increases, one's satisfaction with the setting in which that occurs will decrease. Hence, as MGRS levels increase, the prediction is that job satisfaction should decrease, if the job setting is the source of the role strain. There are multiple studies which suggest male nurse employment is a source of both physiological and personal stress (Chung, 2000; Deane, 2002) and job stress (Bronner, 2003; Ericksen, 2004; Evans, 1997).

Interestingly, among the sample in this population, although 6.7% were high in MGRS, there was no significant relationship between job satisfaction and MGRS levels. The surprising outcome that almost three out of four respondents tested low in MGRS, and that the overall mean of MGRS was in the low category, suggests that role strain is not an important factor for these long time (mean 22+ years) older (mean 50.7 years of

age) men nurses. It is possible that men who experienced significant role strain left nursing at higher rates than women do (NewsRx.com, 2002) or were disproportionately disciplined (Evangelista, 2008). This study cannot evaluate that aspect.

Unfortunately, the lack of younger participants and those new to nursing hampers an analysis of role strain effects across the broader population of men nurses. Consequently, a thorough analysis of the effects of role strain throughout the men nurse population is not possible with this study.

Implications for Nursing Practice

If the results of this small study can be generalized to the wider population of men nurses, then as men remain within the profession, they seek higher education and express greater job satisfaction. This suggests that long-term, older, more educated men nurses are both committed to the profession and potential contributors to change in the way nursing deals with men practitioners.

The 6.6% of this cohort who experienced high levels of MGRS, furthermore, have found their own way to continue in an employment situation that may contribute to their role stress. Men nurses who experience MGRS and are able to manage their responses may be able to teach those skills to younger men nurses who are dealing with the issues for the first time. Though there is no existing mechanism for older men nurses to directly mentor young ones, participation in men nurse organizations, such as the American Association for Men in Nursing, may provide the moral support, guidance, and direction young men need to navigate the rough waters of a highly feminized profession.

Ideally, a sensitivity to the status and pressures men face in the field could be

communicated to women nurses. There currently is considerable resistance by women nurses to the idea that men may be marginalized and disproportionately disciplined within the field, but as new research confirms this, and men nurses express their discomfort more openly, that sensitivity may increase. With increased sensitivity, hopefully, some of the attitudes and restrictions in nursing culture may fall by the wayside, thus allowing men nurses to achieve their highest abilities and goals within the profession.

Implications for Nursing Education

Individuals come into the nursing profession as young adults or in middle adulthood, with readiness to learn at sufficient levels to allow them to progress in the field. Learning readiness is the product of multiple factors that include the individual's past experiences with learning, his or her cultural background, the person's coping mechanisms, orientation to process, locus of control, and level of aspiration to learn (Bastable, 2008). Nursing students arrive in the profession with well-developed gender concepts and experiences, some of which may be malleable, and some which may not be.

The challenge for nursing education is to encourage the growth of young nurses, while simultaneously presenting balanced options for persons of both genders. Commonplace use of the pronoun "she" when referring to a nurse is a clear symptom of the gender disparities currently present in the field.

Learning about the effect of gender roles occurs in the neophyte nurse's first exposure to practice principles and ideals. At that point, they have few notions about nursing and are ready to embrace new concepts that may encourage gender balance.

Educating new nurses to recognize role behaviors, gender differences, and especially the strengths each gender brings to the profession, will aid the development of greater gender balance.

Encouraging men nurses to enter the education realm, and act as mentors to young men nurses, can provide active role models for both male and female incoming nurses.

However, this encouragement is likely not going to come from the existing hierarchy of nursing education, and rather must arise from the actions of men nurses already successful in the discipline.

Recommendations for Future Research

This study sought to evaluate the relationship between masculine gender role stress on job satisfaction among men nurses. The outcome suggests that older, long-term, more educated men in nursing do not experience much role stress and are generally satisfied with their employment. However, the status of young, less educated men who have worked as nurses for less than five years is poorly represented in this sample. That group provides a unique and fertile area for further research, especially given that the percentage of men in nursing is gradually increasing as men fill positions traditionally held by women.

MGRS may affect men who choose to leave nursing, but no previous studies have explored that issue. A study that examined a cohort of such men may discover differing results. Although a non significant inverse relationship between job satisfaction and MGRS was found here, lower levels of job satisfaction in young men nurses may be associated with higher levels of MGRS.

Although there have been strides in the past few years to explore issues facing men nurses that differ from those facing women nurses, the unique experience of men in this field has been poorly examined. Issues of gender segregation within nursing disciplines, and the purposeful exclusion of men nurses from specific disciplines based on gender in relation to nursing culture are fruitful areas of further study.

Unexpected results here that suggest men nurses who prefer male sexual partners may be more uncomfortable with issues involving intellectual adequacy and ability to perform than those who prefer male-female relationships, merit further evaluation as well. Gay men nurses are a significant sub-population within the larger population of men nurses, even though the presence of women nurses who prefer female partners has not been explored. The nurses' choice of sex partners may reflect other elements of role stress, distress, and job satisfaction which remain to be uncovered. Further research involving men nurses in all capacities is warranted, as well.

Limitations of this Study

Although adequate power was obtained (Cohen, 1992), the sample for this study lacked sufficient younger participants, those new to nursing, and those who had undergraduate licensure (LPNs and RNs). In consequence, the study is reflective of the opinions of mature long-time graduate degreed nurses, rather than an across-the-board examination of men nurse views. Given that the sample was selected from Missouri nurses, this study may not generalize across other states, regions or locales, or to other populations of men nurses in disciplines not represented here. The small response rate indicates that men nurses are not well represented overall.

Some participants ($n = 17$) did not complete the entire survey, stopping after demographic data and before answering questions on the MGRS survey. Given the strong emotions expressed by those who commented, it is possible that the personal nature of the MGRS questions caused some potential participants to stop before completing the material. This clearly limits the utility of the existing replies, as it suggests that more modest or inexpressive individuals are not represented in the results.

Conclusion

Men represent a minority in nursing who have until recently experienced limited scholarly interest. Existing studies indicate that men experience bias, discrimination based on sex, and disproportionate levels of discipline within the profession. In the face of a continuing nursing shortage the recruitment and retention of men, as well as the rates at which men leave the profession and elements associated with that turnover, are of concern.

Masculine Gender Roles Stress, an outcome of feeling as though one must perform in a way that crosses the boundaries of one's deeply held beliefs about one's own masculinity, may play a part in men's responses to nursing culture and settings, and may influence job satisfaction in a manner that affects behavior and tenure. This descriptive correlational study examined relationships between MGRS and job satisfaction, as well as demographic variables of age, employment setting, education level, ethnicity, and sexual preference.

Participants consisted of 88 men nurses residing and working in Missouri, contacted by mail, and provided with informed consent. Questionnaires for the study

were accessible online by computer. Completed data were analyzed by non-parametric tests including *Chi* square, Spearman's *rho* and Kendall's *tau b*. Results indicated that rates of MGRS were low among respondents, with less than 7% of this sample scoring high in MGRS. There was a non significant inverse relationship between MGRS and job satisfaction, suggesting the possibility that the greater MGRS experienced, the less satisfied the individual was with his employment. MGRS was not significantly related to age, degree, type of nursing discipline, or sexual preference.

Several respondents commented on the “personal” or “inappropriate” nature of the questionnaire items, one called the questions “intrusive, obnoxious, poorly written, and fails to cater to advanced practice degrees”; however, the majority of the 22 comments suggested additional study directions or explained their answers on individual questions. There was no correlation between comments and MGRS or job satisfaction levels. Incidental findings were that married respondents were more satisfied with their employment and salary than single respondents.

Role Theory was utilized to describe the developmental roots of the MGRS concept, and nursing culture's unwritten codes within a highly feminized profession were discussed. Limitations of the study included the small but appropriately powered sample size, the older age and high degree levels of the participants, and the small number of non graduate nurses who participated. Results, therefore, will be skewed toward the experiences of older, higher degreed, long-time men nurses.

The key findings of this study were the low rates of MGRS among the sample, and that job satisfaction was slightly non significantly related to MGRS levels. Future studies could examine these issues in different nursing populations, including young

lower degreed new men nurses, men who are choosing to leave the profession, and men nurses who prefer male sexual partners. Such studies could provide greater focus on the issues men face in nursing.

The nursing profession benefits by the presence of men in the field. Hopefully, older men nurses can mentor younger ones and provide guidance on managing role strain encountered in this feminized profession. Ideally, female nurses would become more sensitized to the pressures and stress men face in entering and staying in the field.

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Appendix A

Masculine Gender Role Stress (MGRS) Scale

M.G.R.S. RATING SCALE

ID: _____ AGE: _____ DATE: _____
 SEX: M F RACE: _____ MARITAL STATUS: S M D W

Directions: Please rate the following items according to how stressful the situation would be for you. Give each item a rating on the scale of 0 to 5, ranging from not stressful to extremely stressful. For example:

- | | |
|---|---|
| A. Driving a car | 0 |
| B. Discovering you have a serious illness | 4 |
| C. Losing your keys | 2 |

NOT STRESSFUL						EXTREMELY STRESSFUL
0	1	2	3	4	5	

Begin Here:

1. Feeling that you are not in good physical condition _____
2. Telling your spouse that you love her/him _____
3. Being outperformed at work by a woman _____
4. Having to ask for directions when you are lost _____
5. Being unemployed _____
6. Not being able to find a sexual partner _____
7. Having a female boss _____
8. Having your lover say that s/he is not satisfied _____
9. Letting a woman take control of the situation _____
10. Not making enough money _____

* * * Continue on Next Page * * *

NOT STRESSFUL						EXTREMELY STRESSFUL
0	1	2	3	4		5
11.	Being perceived by someone as "gay" or "lesbian"					_____
12.	Telling someone that you feel hurt by what they said					_____
13.	Being married to someone who makes more money than you					_____
14.	Working with people who seem more ambitious than you					_____
15.	Finding you lack the occupational skills to succeed					_____
16.	Losing in a sports competition					_____
17.	Admitting that you are afraid of something					_____
18.	Being with a woman who is more successful than you					_____
19.	Talking with a "feminist"					_____
20.	Being unable to perform sexually					_____
21.	Being perceived as having feminine traits					_____
22.	Having your children see you cry					_____
23.	Being outperformed in a game by a woman					_____
24.	Having people say that you are indecisive					_____
25.	Being too tired for sex when your lover initiates it					_____
26.	Appearing less athletic than a friend					_____
27.	Talking with a woman who is crying					_____
28.	Needing your spouse to work to help support the family					_____
29.	Having others say that you are too emotional					_____
30.	Being unable to become sexually aroused when you want					_____
31.	Being compared unfavorably to men					_____

* * * Continue on Next Page * * *

NOT STRESSFUL						EXTREMELY STRESSFUL
0	1	2	3	4	5	
32. Comforting a male friend who is upset						_____
33. Admitting to your friends that you do housework						_____
34. Working with people who are brighter than yourself						_____
35. Getting passed over for a promotion						_____
36. Knowing you cannot hold your liquor as well as others						_____
37. Having a man put his arm around your shoulder						_____
38. Being with a woman who is much taller than you						_____
39. Staying home during the day with a sick child						_____
40. Getting fired from your job						_____

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Appendix B

Mcloskey-Mueller Satisfaction Scale (MMSS)

MCLOSKEY / MUELLER SATISFACTION SCALE (MMSS) (© 1989)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR CURRENT JOB?

		Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied	Not Applicable
1	Salary	1	2	3	4	8
2	Vacation	1	2	3	4	8
3	Benefit package (insurance, retirement)	1	2	3	4	8
4	Hours that you work	1	2	3	4	8
5	Flexibility in scheduling your hours	1	2	3	4	8
6	Opportunity to work straight days	1	2	3	4	8
7	Opportunity for part-time work	1	2	3	4	8
8	Weekends off per month	1	2	3	4	8
9	Flexibility in scheduling your weekends	1	2	3	4	8
10	Compensation for working weekends	1	2	3	4	8
11	Maternity leave time	1	2	3	4	8
12	Child care facilities for employees' children in the hospital	1	2	3	4	8
13	Your head nurse/nurse manager	1	2	3	4	8
14	Your nursing peers	1	2	3	4	8
15	The physicians you work with	1	2	3	4	8
16	The delivery of care method used on your unit (e.g., functional, team, primary, modular care, patient-centered care)	1	2	3	4	8
17	Opportunities for social contact at work	1	2	3	4	8
18	Opportunities for social contact with your colleagues after work	1	2	3	4	8
19	Opportunities to interact professionally with other disciplines	1	2	3	4	8
20	Opportunities to interact with faculty	1	2	3	4	8
21	Opportunities to belong to department and institutional committees	1	2	3	4	8

		Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied	Not Applicable
22	Control over what goes on in your work setting	1	2	3	4	8
23	Opportunities for career advancement	1	2	3	4	8
24	Recognition of your work from superiors	1	2	3	4	8
25	Recognition of your work from peers	1	2	3	4	8
26	Amount of encouragement and positive feedback	1	2	3	4	8
27	Opportunities to participate in nursing research	1	2	3	4	8
28	Opportunities to write and publish	1	2	3	4	8
29	Your amount of responsibility	1	2	3	4	8
30	Your control of work conditions	1	2	3	4	8
31	Your participation in organizational decision making	1	2	3	4	8

Appendix C
Demographic Data

Please complete the following information about yourself:

1. Your age: _____
2. How many years have you worked in nursing? _____
3. What is the highest education level you have attained in nursing?

LPN _____

RN (ASN) _____

BSN _____

MSN _____

Post-Graduate Certificate _____

DNS/DNP (Clinical doctorate) _____

PhD _____

4. What is your primary area of employment?

Cardiology _____

Dermatology _____

Emergency room/department _____

ENT _____

Family Practice _____

Gastroenterology _____

Hospitalist _____

Medical/Surgical _____

Neurology _____

Nephrology _____

OB/GYN _____

Orthopedics _____

Pulmonology _____

Urgent Care _____

Urology _____

Other (please state) _____

5. Please indicate if you are:

married, partnered, living together _____

single, divorced, separated _____

6. Please indicate your primary ethnic origin:

African American _____

Asian or Chinese _____

European or Caucasian _____

Hispanic or Latino _____

Indian or Hindu _____

Japanese _____

Middle East or Arabian _____

Native American _____

Northern European or Caucasian _____

Unknown _____

Mixed origin _____

7. Please indicate your preference in sexual partners:

Women _____

Men _____

Both Women and Men _____

Appendix D

Participant Invitation Letter



DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Dear Missouri Nurse

You are one of approximately 5000 men nurses currently licensed to practice in Missouri. As a man in nursing, you are being asked to participate in a research study. The purpose of this study is to gain your feedback on your job satisfaction and its relationship to the roles that men encounter in our profession and society.

The survey is located online at the Survey Monkey website. You can access it using this URL: <https://www.surveymonkey.com/s/mennurse>. If you would like to participate in this survey, please access the site and respond to the items listed. The survey consists of approximately 80 items and will take about 15 minutes of your time. We estimate that 500 men nurses will complete this survey. It will remain open until March 15, 2013.

Once you have completed the survey, please click the completion tab provided. This will submit your responses to the data base, and completes your participation. There is an additional page that asks if you would like to receive results of the survey when it is finalized; you may leave your email address there as part of the emailing list. Consent for your participation in this study is implied when you submit your responses. It is important to note that **no** IP addresses will be collected and that your responses are anonymous.

If you have questions or concerns about this study, or experience distress as a result of participation, please contact the study investigators and Duquesne's IRB. Anita Evangelista MSN FNP-BC may be contacted at (417) 343-1485 or evangelistaa@duq.edu, Dr. Richard Zoucha may be contacted at (412) 396-6545 or zoucha@duq.edu. If you think you have been injured as a result of participating in this study please contact the IRB administrator Dr. Joseph Kush at (412) 396-6326, Duquesne University, Rangos Bldg Room 424.

I appreciate the participation of men nurses who help carry out the development of knowledge about men's experiences in and opinions of nursing. These data are needed to allow nursing researchers and professionals to understand the unique views and meet the needs of Missouri's men nurses. Your information will be grouped with the responses from other Missouri men nurses to provide a profile of job satisfaction and role behaviors specific to our state. In addition, information collected during this study will form a foundation for my doctoral dissertation at Duquesne University Department of Nursing, as well as future research papers submitted for publication.

Thank you for your assistance on this important project.

Anita Evangelista, MSN, FNP-BC, AHN-BC
evangelistaa@duq.edu
417-343-1485

Dr. Rick Zoucha
526 Fisher Hall
412-396-6545

Dr. Joseph Kush
Room 424 Rangos Bldg.
412-396-6326

Appendix E
Follow Up Postcard

Please join other men nurses here in Missouri in completing an online survey and questionnaire about your experiences, expectations, and motivations as a man working in nursing. This can be accessed 24/7 for your convenience at:

www.surveymonkey.com/s/mennurse

The study asks men nurses to rate their job satisfaction, their gender role behaviors, and a few demographics (age, education level, marital status, etc.). It should take you about 10 minutes to complete. This information will be private and cannot be traced back to you. More detail on this is available when you go online, and checking the site won't commit you to taking the survey – you can stop at any time. Please take the survey only one time, and complete the survey when you begin it – you won't be able to save responses to go back and complete later.

Your information will be grouped with the responses from other Missouri men nurses to provide a profile of job satisfaction and role behaviors specific to our state. In addition, information collected during this study will form a foundation for my doctoral dissertation at Duquesne University Department of Nursing, as well as future research papers submitted for publication.

Do contact me at (*evangelistaa@duq.edu*) if you have any questions about this study. I appreciate your willingness to help contribute to the development of a knowledge base about men in nursing!

Cordially, Anita Evangelista, MSN, FNP-BC, AHN-BC